Addressing Alcohol and Other Drug Problems in the Partnership Program:

A Self-Study Manual and Best Practices Guideline

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This manual is written for all the dedicated staff and managers of the Wisconsin Partnership Program. I sincerely hope that this manual makes your jobs easier, and that it promotes systems changes to better support you and your members.

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Addressing Alcohol or Drug Problems in the Partnership Program

INTRODUCTION

This is a **self-paced education manual** for Partnership Program staff to learn how to effectively assess and respond to alcohol or drug (AOD) problems among Partnership enrollees (called "members") and members' families. It is a **pragmatic practice-oriented manual** presenting ways to perceive, recognize, and respond to AOD problems in the everyday world of community-based long-term care. The manual is designed for use by a wide range of Partnership staff—social service coordinators (also called social workers or case managers), nurses; nurse practitioners; personal care workers; physicians; physical, occupational, speech, art or recreational therapists; home health aides; clinical managers;[1] and anyone else who interacts with members or with interdisciplinary teams. Agencies may choose to have even wider participation (e.g., information systems, fiscal, and utilization review staff) so that all agency staff can understand and support the agency's approach to AOD problems. Provider network developers and contract managers will need to understand this content in order to promote and maintain relationships with alcohol or drug abuse (AODA) [2] providers.

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1 In this manual the term "staff" is usually meant to include all interdisciplinary team staff, personal care workers, and their managers and supervisors. The latter terms are used only when managers and supervisors are specifically discussed in relation to other staff. "Staff" in the broadest sense can include as many ancillary personnel (e.g., drivers, clinic aids, therapy aids, subcontractors, etc.) as each agency sees fit to include; Chapter 2 will suggest that it is in agencies' best interests to provide all ancillary staff at least basic training in discerning "hidden" AOD problems. "Staff" is usually used as plural.

2 In this manual, "alcohol or drug problems" will replace "alcohol or drug abuse" when discussing individuals (more precisely, the results of individuals' behaviors). "AODA" will be used when referring to the addiction field and its literature and practitioners/providers—for convenience and because it is still the predominant term in that field.

Goals

Primary Goals

- Partnership staff will feel more confident and optimistic about addressing AOD problems
- Partnership staff will recognize and respond effectively to AOD problems among members who accept formal AODA treatment and those who do not
- All parties will have clear and reasonable staff performance expectations for recognizing and responding to AOD problems

Secondary goal

- Partnership members with AOD problems will have improved outcomes—i.e., reduced AOD use, harm, and healthcare costs; and improved quality of life, vocations or avocations, etc. [3]

Structure of the Manual

The manual provides information and guidelines for practice. Long-term care staff of various disciplines and with diverse reading styles and various levels of interest in AODA and research will use this manual. The following methods are used to make the manual both easy to use and adequately detailed:

- Information and guidelines are presented briefly in basic steps and principles
- More detailed information is provided for those interested. This optional information can be found in footnotes, optional background documents, and references.
- Examples are provided throughout the manual, to help learners connect the information to real-world situations
- Practice quizzes are provided (with feedback based on selected answers) at the end of each chapter. The quizzes will help learners confirm and reinforce the major points of each chapter, and to practice applying the methods.[4]
- Citations are provided throughout to tie the content to current evidence-based best practices in the AODA field
- Each chapter proposes solutions for a particular problem or set of problems described by Partnership staff
- Suggestions for agency-wide implementation are provided

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[3] It may appear that these goals are prioritized in reverse order; they are not. Partnership staff articulated systemic, interpersonal, and professional challenges in the expectations of long-term care staff addressing AODA among members and members' families. Clear expectations are necessary to provide reasonable work environments for long-term care staff and agencies. Fortunately the methods that help staff work with AODA issues are also effective in improving members' outcomes.

[4] Eventually the manual will be developed into an on-line interactive training. Until then, learners may be asked to write their quiz answers on a separate sheet of paper. Quiz answer keys (with feedback for each answer choice) are provided in the Supplement, which will also contain optional documents for those seeking additional information.

Chapters are ordered generally from the most general to the most specific. Theory, research, and treatment methodologies from the **AODA field** are explained. These are secondary, however, to the primary focus of helping Partnership staff learn **what they can do about AODA in their practice**—particularly when members refuse AODA treatment. An overview of the chapters is presented in a later section of this introduction. Before then, it is appropriate to describe the background of the problem of AODA in the context of managed long-term care.

Background

The Partnership Program is a community-based long-term care program for frail elders and adults with physical disabilities who need assistance with health management and activities of daily living. Partnership is a fully integrated managed care program in which provider agencies receive capitated payments to provide Medicare and Medicaid health and social services, including acute and primary health care. The Wisconsin Partnership Program employs a member-centered interdisciplinary team model.[5]

Early developers of long-term care programs, including Partnership, did not anticipate the extent to which AOD problems among enrollees would affect the programs. For years, Partnership staff and managers have struggled with the day-to-day realities of AOD problems among members and members' family-caregivers.

The Partnership Program is in a unique situation that requires new approaches to AOD problems. Because it is a fully integrated health and social services program, Partnership pays for and provides social services, including those needed due to AOD use. Most other health care insurance programs or providers cover healthcare, but not social services needed due to AODA. Most healthcare providers and payers have, so far, done little AODA prevention and interventions.[6] As a healthcare entity, Partnership is in relatively uncharted territory in its need to address AODA.

Partnership is also not like AODA treatment and/or behavioral health managed care programs. Behavioral health programs do not pay for health or social services needed after clients complete—or drop out of—AODA treatment. Partnership does. Partnership provides or pays for all needed healthcare and social services, including those needed due to AOD use.

Because of Partnership's unique challenges in addressing AODA, the Wisconsin Department of Health and Family Services applied for and received a grant from the Robert Wood Johnson Foundation to address AODA in Partnership—specifically, to develop trainings and a training manual on AODA for Partnership staff. The Department contracted with the Center for Excellence in Long-Term Care in the University of Wisconsin-Madison School of Nursing to meet with Partnership staff and to research the AODA literature for best practices that would assist Partnership. Partnership staff's input is presented in the next section. (Results of the AODA literature search are presented throughout the manual.)

[5] For more information, see www.dhfs.state.wi.us/LTCare.

Partnership Staff Input

Partnership administrators and interdisciplinary team staff were interviewed about their experiences with AODA among members and what was needed from an AODA training. Since the primary goal of the project is to make AOD problems less difficult for staff and agencies, this input was the foundation for this manual. The manual addresses all of their concerns. Partnership staff's experiences and perspectives are summarized below.

It should be noted that Partnership staff are by no means alone in their struggles with AODA. Research shows that the **majority** of healthcare providers and long-term care case managers have received little or no training on AOD problems, lack the knowledge and skills to assess AOD problems, and do not know how to respond when there is an AOD problem.[7] Partnership staff express similar concerns, as follows:

- In addition to feeling a lack of confidence and competence in addressing AODA, the major effect of AODA upon staff is the sense of futility and hopelessness in dealing with members who repeatedly harm themselves and sabotage staff's hard work.
- Teams serving younger people with disabilities said AODA feels like one of their major challenges, along with mental illness, and that they often co-occur. These teams were more likely to report feeling systemic and personal pressure: "They [state and federal overseers] expect us to be responsible for everything, but the truth is, we can't control these people." "Everyone just tells us to try harder, but nothing works."
- Some teams serving only people over age 55 said that AODA is an infrequent problem. When informed of recent evidence that AOD problems are usually overlooked among elders, and that special assessments are needed, (5, 6) staff expressed eagerness to learn about these. They also requested information on behavioral and physical health clues that AODA may be an issue, and on health effects of AODA.
- A few staff asked for clarification on which interdisciplinary team staff should be responsible for addressing AODA.
- Staff varied in their level of interest in learning about AODA
- Most teams requested guidelines on when to refer for AODA services and how to establish working relationships with AODA providers.
- Most teams cited inadequate local AODA resources for either abstinence or reduction.
- Most teams reported that AODA among family members is a greater problem than AODA among enrollees. AOD problems in families raise questions of financial exploitation, neglect or poor quality of care, diversion of pain meds, unsafe environments if drug dealing is present, etc. While Partnership staff have clear abuse and neglect guidelines to follow, in less blatant situations there are complex questions involving cultural and values differences.

[7] As a federally-sponsored AODA expert panel put it, "Many clinicians and other care providers in community agencies retain the long-standing notion that clients are generally resistant to change, unmotivated, and in denial of problems associated with their substance abuse disorders. As a result, clinicians are hesitant to work with this population. Some of these attitudes also persist in the specialist treatment community" (1) (2), (3, 4)

- Members very often disclose different (even conflicting) information to different staff. Because of this, most staff said that all interdisciplinary team members and their supervisors should receive AODA training, so that all are more competent to "seize the moment" when AOD problems are evident and/or when the member is open to talk about it. Staff requested that trainings be made available for direct care workers as well.
- Some staff reported having had one-day AODA trainings several years ago, but there had been no follow-through to help them use the information or for other staff to procure it. It appeared that some who had attended trainings had little more confidence than others. They generally said they wanted information, but also wanted help implementing it, including follow-up sessions.

This manual addresses all of these problems and requests articulated by Partnership staff and managers. The following section provides an overview of the manual content and organization.

Content and Organization

Each chapter in this manual is designed to **solve** a particular problem or set of **problems expressed by Partnership staff**. In this way, and with many "how-to" examples and practice quizzes at the end of each chapter, the manual stays focused on **practical, real-world solutions**.

Because AODA is such an emotional, confusing, and controversial topic, **Chapter 1** proposes a way to perceive AODA that makes it far easier to integrate into long-term care. Long-term care staff have already been struggling with AODA for years; this history could be a barrier to learning about AODA, so it is directly addressed in Chapter 1. Staff are encouraged to recognize conflicts over AODA as the result of **systems**, not personalities or individuals. Staff can agree to the shared goal of making AODA easier to cope with. In order to meet that goal, staff can agree to replace their own personal views with a **shared model** of **AODA as chronic health condition** similar to diabetes or hypertension. This alone will reduce disagreements and will make AODA less foreign to the expertise of long-term care practitioners.

It is not uncommon in long-term care that AODA appears as a **coping mechanism** in response to major losses from sudden disability, health problems, loss of spouse or social role, etc. In these instances, the AODA might resolve as soon as the underlying emotions and conditions are addressed. (Examples are provided in the chapter.) For this reason, it is recommended that Partnership staff not only address AODA directly, but also always assess for and address any underlying (contributory) emotions and needs such as grief, loneliness, loss of purpose in life, etc.

Most of the following chapters present specific interventions Partnership staff can use to address AOD problems. However, there is a widespread view in the U.S. that AODA is rare among elders. Some Partnership staff may need to be persuaded that AODA is common among elders, before such staff would be motivated to learn the interventions for AODA. Some other staff may need to be persuaded that AODA is part of long-term care, as it greatly impacts health, healthcare costs, and functional status. For these reasons, **Chapter 2 focuses on recognizing AOD problems**. This chapter provides evidence that AOD problems are in fact common, costly, and usually overlooked—among elders, and among younger people with disabilities as well.

Chapter 3 presents the intervention that Partnership staff repeatedly voiced as their primary concern: "What do we do with members (or families) who refuse AODA treatment and who won't cut back or quit?" This includes all those "toughest cases" of community-based long-term care—members who drink, misuse prescription or street drugs, smoke (often with oxygen), and generally fail to follow any advice. In these situations, the only thing Partnership staff can do is negotiate with the member to try to make them[8] safer, to try to reduce the risk or harm likely to result from the member's choices. Such "**harm reduction**" can range from protective placement (e.g., court order into a nursing home) through emergency hospitalization, to removing rugs the member might trip over. Harm reduction principles, controversies, and examples are provided in this chapter.

In addition to addressing the most burning issue for Partnership staff, harm reduction is also the **most general** intervention, because it is something staff should always do whenever there is risk of harm. As noted above, harm reduction may involve "last resort" interventions for people with severe on-going AOD problems; but harm reduction may also be needed for people without AOD problems, or those who are cutting back or trying to abstain. Harm reduction is a general response to any kind of risk. As such, harm reduction will be done in addition to the more specific interventions intended to support reduced AOD use. Those more specific interventions are presented as Solutions 4 through 8, again in order of general to specific.

Chapter 4 is the most basic intervention for AOD problems. The official AODA term for the intervention is "**brief interventions** using the FRAMES acronym." It is providing objective **F**eedback about AOD problems, acknowledging change as the individual's **R**esponsibility, giving **A**dvice to cut back or abstain, presenting a **M**enu of options from which to choose, providing **E**mpathy, and **S**upporting **S**elf-Efficacy (or self-confidence) and pragmatic **S**upports to change. This intervention was specifically developed for use by non-AODA providers (so far mostly healthcare providers). Only four or five 10- to 60- minute sessions of such brief interventions have proven effective in getting non-dependent persons to cut back on AOD use, and dependent persons to agree to formal AODA treatment. This chapter provides research evidence of the efficacy of brief interventions using FRAMES, and explains the method. Examples, scripts of what to say, and a practice quiz will help learners practice with the FRAMES steps. Doing so provides a clear, structured way to talk about AODA with members and families—something Partnership staff identified as challenging for them.

Chapter 5 deals with **what to do if a member refuses to cut back or abstain** even after brief interventions with FRAMES. It is fairly common, in fact, for people to be unwilling to change their AOD use. Partnership staff repeatedly asked for what the next steps are; what else can they do? In fact, research shows that specific interventions are effective in helping people move from "denial" of their AOD problem to being ready and able to change their AOD use. These interventions are "motivational enhancement therapies (MET)" based on the "five stages of change." The evidence for and principles of MET are explained in this chapter, as are many examples and scripts to show how to do motivational enhancement.

[8] To avoid awkward "she or he" constructions, third-person plural pronouns are used to refer to single references such as "member." Although numerically inaccurate, this is an accepted style of non-sexist language. (7)

This method is very helpful because it creates **smaller steps for success** for staff and members. Trying to "make" members abstain immediately is usually an unrealistic goal that only creates frustration and discouragement among staff and resistance from members. In using MET, expectations of staff (and members) are much more reasonable: Staff need only recognize **which stage** of change the member is in and **adapt their interventions** with the goal of helping the member **progress to the next stage** of change. Smaller successes can be celebrated. Staff will not feel so "burnt out" on AODA. (As noted above, harm reduction is also done as necessary until the member is willing to cut back or abstain.)

Moving from these **general** interventions—harm reduction, brief interventions using FRAMES, and MET—Solutions 6 and 7 next provide **more specific** focus on two topics.

Chapter 6 focuses on the "M" of FRAMES—the **Menu of options for cutting back or abstaining** from AOD use. This chapter presents all of the major AODA treatment options. Some of the treatment options include things that members and families can do on their own—for example, setting a drinking goal, keeping a drinking diary, noticing what emotions or situations are likely to trigger AOD use. For members who refuse formal AODA treatment, such options can be helpful steps for Partnership staff to suggest to members. The overview of formal AODA treatment, plus some advice on how to negotiate with AODA providers, will help Partnership staff and agencies advocate for their members in need of AODA treatment.

Chapter 7 focuses specifically on **setting limits**. Because of conflicting models of AODA and Partnership's unique position as a fully integrated health and social service managed care program, Partnership staff have often felt trapped between "**enabling**" and **"abandonment**." They fear they're "enabling" AODA by "rescuing" members from the consequences of their AOD use (a view derived from the traditional view that addicts must hit bottom before they'll be ready to change). Yet Partnership cannot refuse to provide **covered** services without risk of negligence ("abandonment"). This chapter provides a way out of this thoroughly unhelpful dilemma. It provides a list of guidelines staff can use to set limits. As always, "how-to" examples are provided.

Chapter 8 discusses **cultural competency**. Since Partnership agencies already have cultural competency requirements, this chapter focuses on AOD problems. Because this is so important with AODA, it is saved until later, after the common misperceptions of AODA have been disproved and the basic interventions have been learned.

Many Partnership staff reported that AODA among members' families is a bigger problem than AODA among members. **Chapter 9**, **"Addressing Family/Caregivers' AOD Use**," addresses this complex issue. Family AOD problems put members at risk of abuse, neglect, or harm. Staff have often felt unprepared to even broach the subject, let alone feel that they could help in any way. All of the previously covered methods and principles are applied in examples of addressing AOD problems with family members.

At the end of each chapter are sections on **Organizational and Implementation Issues.** Interdisciplinary team staff are often eager to discuss such issues, so these sections are included for all interested parties to read. Managers will need to read the entire manual to understand the

changes recommended in it. Each agency will implement these practices in its own way, but some general suggestions are proposed to assist with implementation.

Summary

It is hoped that users will not be overwhelmed at this point; by way of reassurance, approximately half of this manual's content is the examples and quizzes. Partnership staff are not expected to become AODA practitioners. This manual presents some very basic interventions developed for use by non-AODA practitioners. The most basic intervention here (brief interventions using FRAMES) can be done in 10 to 15 minutes by non-AODA practitioners.[9] Additional techniques (such as helping members develop and practice new skills) that take longer are **only** needed for members who **refuse** formal AODA treatment. Evidence (presented in Chapter 2) indicates that Partnership agencies are very likely to attain improved consumer outcomes and significant savings in reduced healthcare costs by implementing the interventions presented in this manual.

Several initiatives are beginning at the national and state level to integrate the separate service systems of health care, mental health care, and AODA treatment. Unfortunately, such integration has not yet occurred in most places. As usual, Wisconsin Partnership agencies are (by necessity if not by choice) on the cutting edge as they seek ways to address members' AOD problems and mental health needs.

The experiences, perspectives, and contributions of Wisconsin Partnership agencies and staff have provided the foundation and inspiration for this manual. It is hoped that this manual proves helpful in the daily work of Partnership staff, and that it contributes to the development of more humane (for all parties), effective, and consumer-centered health and human service systems.

[9] Brief interventions using the "FRAMES" acronym has been proven in extensive research to be effective; see references in Chapter 4.

Chapter

1

Chapter 1–Integrating AODA into Long-Term Care

Introduction

Partnership staff reported:
"We don't even agree on what AODA is. It's so emotional; team members disagree on it. It's too hard to deal with."

AODA is difficult to deal with for many reasons, including these:

1) Everyone has already been affected by AODA in their personal lives, and
2) Everyone has different, sometimes conflicting, theories and attitudes about AODA and people with AODA.

Adult education research tells us that before adults can learn new information, they need to be able to express their current "personal theories" about the topic. This is especially important for emotional topics, which AODA can certainly be. Also, long-term care staff have been struggling with AODA for years, often without adequate training or clear policies. Most users of this manual come to it with a history of difficult experiences with AODA in their work and/or their personal lives. With such histories, and the fact that everyone has their own theories and emotions around AODA, it is no wonder that interdisciplinary teams and staff and managers have had disagreements and difficulties through the years.

How are interdisciplinary teams supposed to reach consensus on AOD problems, given the above? The first step is to "back up" to see the bigger picture, to look beyond individuals, personalities, and interpersonal conflicts, to recognize the **systems** that contribute to our situation. A familiar rule in quality improvement is the 85% rule, which reminds us that 85% of our problems result from systems, not individuals or personalities. Shifting to "systems thinking" can help us relax and be more patient with our differences, even expect them.

The next step is for everyone in an agency to agree to a **shared goal**, and to work together toward that goal. In this case, **the goal is to make AODA less stressful** for Partnership staff. The third step is that, in order to reach that shared goal, individuals agree to keep personal theories personal, and use **shared models of AODA** that are likely to be more effective for the agency, staff, and members. The more effective models of AODA are presented in Part II of this chapter.

First, let us look more closely at some of the influences that shape how each individual feels and thinks about AODA.

Part I – Why AODA Is So Difficult

Everyone Is Personally Affected by AODA

Everyone is personally impacted by AODA. Following are statistics on AOD problems among U.S. adults.(8, 9, 10) Assuming that Partnership staff and managers are typical U.S. adults, these statistics are true of all Partnership staff and managers as well:

- More than 50% have AOD problems in immediate family
- 13% have or have had serious AOD problems including addiction/dependency
- 20% currently drink more than the recommended limits
  (14 drinks/week for men < 65; 7 drinks/week for women < 65;
  no more than 5 drinks/occasion for men, 4 for women)
- 50% have tried illegal drugs (of that, 76% marijuana, 21% cocaine). [10]

Given these figures, it is not surprising that people have various emotional reactions and disagreements about AOD use. So of course AODA is an extremely difficult issue. It is emotional and confusing and people disagree. Any group—interdisciplinary teams, managers, members, families, anyone—will have a mix of the above AOD histories and experiences. It is not realistic to expect everyone's personal views about AOD to be the same. Since personal views and emotions about AOD vary among people, it is unlikely that consensus can be reached if personal views are used.

Managed Long-Term Care Was Not Originally Designed to Manage AODA

Partnership was created as a fully integrated Medicaid (and later, Medicaid and Medicare) long-term care program for frail elders and adults with physical disabilities who met eligibility for nursing homes. When Partnership was originally developed, no special attention was given to the fact that individuals with long-term care needs would also have AOD problems and/or mental health issues. The U.S. has separated health and social services so much that truly holistic, person-centered services are a rarity. Partnership staff have been caught in conflicts between the separate disciplines of long-term care, mental health, and AODA. These separate systems have very little crossover of knowledge and skills, and sometimes even have conflicting philosophies.[11]

Another systems problem is that, in the context of managed care, there is a widespread assumption that "case managers" are expected to manage—as in control—members' service costs and even their behaviors. This has led to unrealistic expectations that Partnership staff must be able to "make" people stop drinking or using drugs. They cannot. In fact, with severe AODA,

[10] Most people in the U.S. stop heavy drinking and use of illicit drugs by the age of 30 (Chen and Kandel 1995) (11)

[11] These are discussed further in Chapter 11, "Working with AODA Providers."

high healthcare costs are almost inevitable, and Partnership staff can only partly reduce those in some cases.[12]

Unrealistic demands upon community-based long-term care programs are created by federal and state requirements that providers ensure members' health and safety 24 hours/day. These requirements fail to clarify providers' responsibilities when competent adult members make unhealthy and unsafe choices. Similarly, "standards of practice" fail to clarify practitioners' responsibilities when members refuse to follow recommendations.

All of these **systems** issues have put Partnership staff and agencies in an awkward position with AODA. To complicate matters even more, the U.S. has numerous conflicting theories of AODA. The next section reviews those various theories. Again, the purpose here is to lay out all the systems problems that explain why AODA has been a difficult issue for many long-term care staff, including Partnership staff. The last sections of this chapter will present two theories of AODA that will make it far easier to integrate into long-term care practice. Following chapters (as explained in the Introduction) address the other systems problems as well.

Theories of AODA

What is AODA? Is it a chosen lifestyle? A blameworthy defect in moral character? A lack of willpower? A failure of personal responsibility? A disease? A spiritual disorder? A form of "noncompliance"? We've all heard all of these "explanations" for AODA, and people differ in their views. Most of you are familiar with the major theories of AODA[13]:

Medical or Disease Model: AODA is a primary, progressive, and fatal disease.

The disease model arose in the U.S. since the 1950's, through influences from Alcoholics Anonymous and the fields of medicine and psychiatry(14) . The disease model is upheld by research evidence that AOD dependency:

- Occurs in non-human animals
- Can be inherited (15, 16)
- Creates brain biochemical changes (16, 17, 18)
- May be caused by brain biochemical imbalances (15, 17, 19, 20, 21)
- Can be treated with prescribed medications (in addition to behavioral changes) (12, 19, 21, 22)

Psychosocial Models: This is an "umbrella" term encompassing a range of theories from behavioral science and psychology.

Behavioral or Cognitive-Behavioral Models

Coping: Drugs and alcohol are used to cope with distressing feelings.

Learned Habit: AODA is a learned habit that can be unlearned with practice.

Coping and learned habit views overlap: AOD use can (temporarily) decrease distressing feelings, thus positively reinforcing (rewarding) the use. Once a person becomes

[12] More details on the impact of AOD problems on healthcare costs are provided in Chapter 2.

[13] The theories overlap, and various writers have different categorizations. Coping skills, for instance, can be categorized under psychological or behavioral theories. This is a partial list of only the key theories of AODA. For more details, see optional documents or (12, 13)

dependent on (physically addicted to) a substance, a prime motivator to keep using is to avoid withdrawal symptoms. The coping and learning models are both "behavioral" or "cognitive-behavioral" models.

Relational: AOD becomes a "significant other" for the individual. *Attachment theory* suggests that those who do not develop secure attachments in childhood are more likely to attach to AOD as teens or adults (23).

Community or Sociocultural: Community norms and beliefs about AODA affect individuals' use.

Political: AODA can be (statistically) explained by socioeconomic and political forces such as industry subsidies, marketing (targeted to specific populations) and poverty and oppression that create hopelessness

Spiritual Model: AODA is spiritual disorder healed through spirituality

This model is often combined with other models. "Spirituality" in its broadest sense can mean feeling worthwhile, having some sense or purpose in life.

Most people regard each of these models as incomplete on its own; the AODA field now generally accepts the broadest conception of AODA as a biological, social, psychological, and spiritual disorder. This **"bio-psychosocial-spiritual model"** is broad enough to recognize many of the factors that may be affecting individuals with AOD problems. Chapter 4 will show that the most effective AODA treatments tend to include an eclectic mix of the above theories and corresponding treatment methods.[14] Long-term care involves a similar recognition of all of the domains of human life, so this will not seem too different from your usual practice.

There is one more model of AODA that requires special attention, and that is the "moral model." **The moral model holds that AODA results from defects in moral character or willpower.**[15] The moral model is quite prevalent in the U.S. (more so than in other countries). The moral model influences people's attitudes about AODA and people with AODA. It causes people to be judgmental and critical of people with AODA. In recent years, the moral model has been rejected in the AODA field, but it remains common in the U.S. The next section addresses this in more detail, and presents an alternative model that can make AODA easier for Partnership teams to deal with.

Part II—A Better Working Model of AODA

The Moral Model as Ineffective

The **moral model** was a central part of "traditional" AODA treatment in the U.S., but it has now been rejected by most of the AODA field on ideological and pragmatic grounds. **The moral model has been shown through research to be a less effective approach to AODA** when compared to more collaborative approaches. (8, 24, 25, 26, 27, 28, 29, 30)

14 Each theory implies different treatment approaches. The disease model, for instance, implies that one needs professional assessment, diagnosis, and treatment, including prescribed medications if available. The spiritual model implies that one needs to address spirituality.

Unfortunately, the moral model continues to affect many people's attitudes. This is true despite the prevalence of the disease model in the U.S. In the U.S., the moral model and the disease model co-exist as the two most prevalent theories of AODA. They obviously conflict, but people commonly vacillate between the two. In fact, healthcare providers can have very strong tendencies toward the moral model. A significant minority of nurses and doctors still reflect the moral model in their attitudes toward people with AODA. (24, 26) Research has shown that professionals' negative attitudes lead to poorer outcomes in health treatment and in AODA treatment. (28, 31)

The moral model has been effective in motivating some individuals to change their AOD use.[16] But for many people, the moral model generates defensiveness and resistance. Partnership staff have reported that they struggle most with how to work with people who refuse AODA treatment. These are people who have already rejected others' attempts to shame them and blame them into quitting. Thus, while the moral model may work for a minority of individuals with AOD problems, it is not at all likely to be effective with Partnership members who continue to use alcohol or drugs. Moreover, the moral model tends to generate emotions of anger and frustration among those who hold it. If you hold the moral model, you dislike people with AODA, you don't want to work with them, you think they are hopeless. That makes your job at Partnership more difficult **for you**. Holding the moral model actually makes **you** feel worse.

Some staff may hold the moral model while other staff reject it. Interdisciplinary team meetings can be split over this, as staff find themselves on opposite sides of this fundamental disagreement. Between this and everyone's personal history with and emotions about AODA, it is not surprising that AODA becomes a confusing and contentious issue. As noted earlier in this chapter, what is needed is a **shared model of AODA** that everyone agrees to use in their work. The shared model can be a **neutral territory** that avoids the disease-versus-immorality argument, which alone will make **your work easier**.

AODA as a Chronic Condition

There is a recent model of AODA that goes beyond the disease model to hold that **AODA is a chronic health condition with genetic, biochemical, and behavioral components**—like diabetes, high blood pressure, high cholesterol, high lipids, and obesity.[17] Of note is that none of these chronic conditions are truly diseases. Placing AODA in the chronic condition category is more accurate than the disease model. It is in part due to weaknesses in the disease model—the ways in which it doesn't "ring true" for people—that many tend to fall into the moral model. The chronic condition model can reduce this tendency, as will be explained next.

The chronic condition model **describes** AODA in a way that is very familiar and makes sense for long-term care staff, who (by definition) are experts in helping people with chronic health conditions. It is useful as a ("prescriptive") **guide**, because it **guides you respond to AODA in the same way as you respond to other chronic conditions** like diabetes, high blood pressure, high cholesterol, high lipids (excess fat in blood), and obesity. We'll look at how you do that in

16 The moral model is not to be confused with a recognition of spirituality, although in most religions the two are conflated.

17 Although the chronic condition paradigm is a medical paradigm, it is best described as a sociomedical model in that it incorporates sociological factors as well as genetic and biochemical factors.

detail in the next section, but let's first explore all the ways that AODA really is like diabetes, high blood pressure, high fat levels, and obesity.

All of the chronic conditions listed above, plus AODA, have all of the following characteristics:

Genetic Factors

- Proven through family tree studies and twin and adoption studies
- Contributing genes found

Biochemical Factors

- It is not always clear yet which are contributing factors and which are effects, especially concerning brain chemicals and addictive substances
- Hormones and metabolism factors affect the chronic conditions (e.g., carbohydrate cravings among alcoholics[18])

Unpredictable course

- All of the above-listed chronic conditions are known to **increase risk** of death and health crises (e.g., heart attack, stroke, kidney failure)
- Yet the **majority** of people with the conditions do not actually have those health crises
- For each individual, the course is **unpredictable and often fluctuates over years**
- *For AODA:*
    - Only about 20% of people with harmful drinking are alcoholics; 80% are not(34)
    - Only 10% of heavy drinkers or alcoholics develop liver failure
    - Approximately 50% of alcoholics recover without formal treatment (33, 35)
    -

Late onset of symptoms

- All of the above-listed chronic conditions are usually overlooked until very late
- Regular screening is important to find individuals with these conditions
- Early intervention and prevention is effective in improving the conditions and outcomes[19]

Environmental Factors

- Societal norms (e.g., current diet and lifestyle norms in the U.S. and in Wisconsin)
    - The behaviors associated with the above chronic conditions—and with AODA—are generally socially approved (eating sweets and high-fat foods, watching TV, sedentary jobs, drinking alcohol, etc.) until and unless the person develops a chronic condition or problems
- Marketing (in general and targeted toward particular populations; e.g., 40% of alcohol marketing is directed at African Americans (36))
- Economic

[18] "Some alcoholics may self-medicate with carbohydrates between drinks," (32). This is interesting to consider interactive biochemical factors in the dietary non-adherence of people with diabetes and drinking problems. Such biochemical evidence also replaces the traditional myth of "the addictive personality" with scientific facts (33).

[19] Details on improved outcomes are provided in Chapter 2.

- Political (quality and distribution of resources, subsidies of, e.g., tobacco industry; racism, stresses of membership in devalued social groups,)
- Cultural/ sub-cultural beliefs and norms
- Family "culture"—- beliefs, norms, interpersonal "systems" or dynamics

Behavioral Factors

- Attitudes, habits, and skills in recognizing, planning, and implementing healthy diet, exercise, and coping with stress, emotions, and interpersonal issues
- Treatment is long-term preventive management, not cure
- Treatment usually includes medications and changing longstanding patterns
- People often take years to change their behaviors
- Consumer adherence to medications and treatments averages 30 to 70% for all of the above-listed conditions, including AODA

"Chronic Conditions" Need Not Be "Diseases"

- High blood pressure, high cholesterol, high lipid levels, and obesity (and, to some, adult-onset diabetes) are not, strictly speaking, diseases; they are the result of a mix of all the above factors. Similarly, AODA is more accurately categorized as a chronic health condition rather than a disease.[20]

"Health Moralism" in Response to Chronic Conditions with Behavioral Components

- An interesting and undeniably important factor in these chronic conditions is how we sometimes **blame people** for their condition and resent those who do not make the necessary behavioral changes. This "health moralism"—moral judgment concerning health—is widespread in the U.S. dominant culture. It is often framed as individuals' rights versus responsibilities, and the individual versus "society" in the distribution of scarce resources. (This health moralism does not exist in all other countries and cultures.)
- Death or disabilities resulting from chronic conditions and/or related behaviors can impair functioning, work, social participation, and quality of life. As such, these outcomes may greatly affect others in the individual's life—family, caregivers, payers.

As you can see, the similarities between AODA and the above-listed chronic diseases are strong. The differences between AODA and other chronic conditions are a matter of degree. That is, AODA differs from diabetes, high blood pressure, etc., not by being a different entity (they are all chronic conditions), but that AODA tends to involve higher degrees of biochemical (addictive) properties and harms in some areas. To summarize this point of how AODA differs from the other chronic conditions:

- AODA involves **addictive** substances, which by definition act directly on the brain and cause strong cravings to use, even against the user's better judgment or desire to abstain.

[20] Some argue against any medical view of AODA, holding instead that AOD use is a normal part of human life with benefits and harms just like most other activities. Proponents of this view reject the "us-them" split of helpers versus users (when in fact many helpers also use), and argue that users should not be pathologized as sick. See Chapter 3 for more on this view, which prevails mostly among proponents of harm reduction, an alternative approach to AODA.

- Because AODA impairs behaviors, attitudes, cognition, interactions, and motor control, it causes far more harm to others and more harm in relationships and in legal, employment, and social spheres than do the other conditions.[21]

"But," some might ask, "we can **treat** those other chronic conditions with medications. With AODA, the person has to change." It is true that the other chronic conditions (hypertension, high cholesterol) can sometimes be controlled through medications only. With AODA, medications alone are never sufficient; the individual must make some behavioral changes as well.[22] Yet treatment of addiction is as successful as treatment of other chronic diseases including diabetes, hypertension and asthma (37).

"But," some might respond, "alcoholics and drug addicts are **noncompliant**, so no treatment works with them." Actually, non-adherence (noncompliance) rates are no worse for AODA than for the other chronic conditions:

Treatment Adherence Rates for Various Health Conditions

CONDITION	Average Treatment Adherence Rates
Diabetes (Type I)	30-50 %
Diet	< 30 %
Foot Care	
Medication	< 50 %
Hypertension (Rx-dependent)	50-60 %
Diet	< 30 %
Medication	< 30 %
Asthma (Adult)	60-80 %
Medications (in general)	< 30 %
Addiction (Abstinence-Oriented Treatment)	10-30 %
Treatment Attendance	40 % %
Opioid Dependence (Methadone Maintenance Therapy)	90 %

Institute of Medicine, 1998

Implications for Practice

What difference does it make for you to view AODA as a chronic condition similar to diabetes, high blood pressure, high cholesterol, high lipids, and obesity? Viewing AODA as a chronic condition does the following three things to make AODA easier for long-term care staff to deal with:

- **Provides a shared model of AODA to replace personal views of AODA**, which vary greatly and make consensus difficult (as discussed in Part I A). Instead of having conflicts and confusions about AODA, everyone in your agency can agree to regard it as a chronic condition like diabetes, high blood pressure, etc.

[21] Mental health problems very often co-occur with AOD problems and may contribute to some of these negative outcomes.

[22] It is tempting here to say that the person must "want to quit." This is partially true; but with some of the more addictive substances such as heroine, people can want desperately to quit and still be unable to. Also, wanting as in wishing is not the same as actually changing behaviors. This will be discussed in detail Chapter 5.

- Discourages use of the moral model for AODA. Some of the moral model ("health moralism") does arise in response to individuals' poor self-management of their diabetes, obesity, high blood pressure, etc. Yet by placing AODA in the same category as the other chronic conditions, we can now ask, "Would we react this way if this were a diabetic eating cake?" This alone is a powerful question to **de-escalate the emotions and disagreements** that commonly arise around AODA.
- Provides opportunities to **build on existing expertise of long-term care practitioners** who regularly deal with chronic conditions. (Details are explained below.)

In short, viewing AODA as a chronic condition is a first step to making your work **easier.** Viewing AODA as a chronic condition can make you **more effective** whenever AODA is involved, as well. So let's look at this in more detail.

Read through this list of things you already know about chronic conditions such as diabetes, high blood pressure, high cholesterol, and obesity:

- These are all very common conditions that many people have to some extent or another (a matter of degree more than completely separate categories).
- Practitioners' roles and competences are usually clear for working with people with chronic conditions.
- Practitioners can benefit people by doing early intervention and prevention, including screening.
- Practitioners can refer people to specialists, and can supplement specialists' care with on-going support.
- No one expects chronic conditions to completely go away; no one expects cures.
- "Success" is improved outcomes, not 100% eradication of the chronic condition.
- People can manage their chronic conditions sometimes without professional help.
- Practitioners can learn ways to help consumers manage the chronic condition. Practitioners educate consumers in terms they understand, help them develop skills, and help them plan and implement the new skills and behavioral changes.
- Practitioners often ask about the consumer's reasons for noncompliance and often adjust treatment to accommodate those reasons.
- When a chronic condition worsens, practitioners look for factors that may have caused the change.
- Practitioners ask consumers about times when the condition was under control, and explore what factors helped then.
- If a particular treatment proves ineffective, practitioners usually try something else.
- Practitioners can situate chronic conditions within a holistic view of the person.
- Except in the most extreme cases of harmful noncompliance, there is usually not a high level of conflict over chronic conditions: Practitioners do not usually discharge consumers who

don't follow recommendations. Practitioners usually do not become upset, and feel their work is futile when exacerbations or non-adherence occurs.

- Chronic conditions are usually not stigmatized or judged as moral defects.
- Chronic conditions are not usually perceived as the most important thing about an individual.
- Few people argue over whether chronic conditions are "diseases" or "choices"; they're recognized as a complex mix of contributing factors including genetic, biochemical, environmental, and to various extents, behavioral.
- Chronic conditions are matters of public health and community welfare, not merely individuals' problems.

These things are generally true about diabetes, high blood pressure, high cholesterol, high lipids, and obesity. **Now read through the list again with AODA as the chronic condition**. Do you see how perceiving AODA as a chronic condition will be **beneficial to you** in your work? Emotions run less high. Disagreements among personal views of AODA can be reduced if everyone agrees to regard AODA as chronic condition. AODA will feel less stressful. AODA will feel less foreign. Rather than feel that you have no expertise at all with AODA, you can just expand the **expertise you already have with chronic conditions** to AODA—another chronic condition. The next section expands upon this last point.

Responding to AODA as a Chronic Condition
You already have experience and expertise in working with people with chronic conditions. You always focus on consumer outcomes, negotiating to promote the consumer's desired outcomes. To summarize what you do now for chronic conditions:

Addressing Chronic Conditions

- Regular screening (as part of prevention)
- Feedback on objective information indicating the chronic condition
- Information on the causes and influencing factors of the condition
- Information on options for treatment and management of the condition
- Development of new skills to manage the condition
- Support to practice planning, implementing, and evaluating the new skills
- Follow up to evaluate treatment effectiveness and to resolve problems in implementing treatment and/or self-management strategies

All of these interventions that you do now for other chronic conditions, you will also do for AODA. (Actually, you'll only need to do these interventions for the members who refuse formal AODA treatment.) The following chapters will explain these interventions for AODA in more detail.

First, however, it is important to consider a fairly common phenomenon in long-term care, which is not acknowledged as much in the AODA literature. In long-term care, AOD misuse often

appears as a **coping mechanism in response to major losses** from health problems, loss of spouse, siblings, social roles, etc. In these instances, the AODA sometimes resolves as soon as these underlying emotions and conditions are addressed. For this reason, it is recommended that Partnership staff not only address AODA directly, but also always assess for and address any underlying (contributory) emotions such as depression, grief, anxiety, loneliness, loss of purpose in life, etc. The point is that doing so has in numerous cases been effective—more effective than simply diagnosing and treating AODA directly. A few case studies from long-term care are the best way to illustrate this.

Example of Addressing Underlying Factors When AOD Use Is For Coping

Mike *is a 28 year old who recently came home from 7 months in the hospital and rehab after a logging accident that left him with quadriplegia. Mike had previously worked on the family farm and as a logger, and was involved in sports and coaching. He is now drunk almost every night, and starting to drink in the daytime.*

You're tempted to *have Mike diagnosed as an alcoholic and to refer him for AODA treatment.*

Instead*, you pay attention to the fact that Mike never drank much, and that this heavy drinking is new for him. His parents say his personality has changed from happy and out-going to agitated, angry, and unhappy. He has not gone out of his apartment and does not want people to visit him.*

You make sure Mike understands the harms from drinking so much, and you do advise him to cut back or quit. (How to do this is explained in chapters 4 and 5.)

Given the whole picture, it appears that Mike is struggling with the loss and adjustment of coming home with quadriplegia, and that he may be using alcohol to try to drown out his thoughts and feelings. You discuss this with the rest of the interdisciplinary team, and everyone agrees to focus on helping Mike regain a sense of life and purpose.

The plan involves (in a nutshell) Mike's whole interdisciplinary team helping Mike to connect with spinal cord injury peers with full and active lives, get back into socializing, start coaching again, and start thinking about school and jobs. Mike is at first cynical, but staff are honest and nonjudgmental with him and keep encouraging him to focus on positives: It helps, and his drinking drops off significantly within a few weeks. Team members continue to discuss his drinking with him, helping him recognize what he was doing and making choices and plans for other ways to cope when life seems bleak.

So the shared model you will use for AODA is the chronic condition model. However, you will also be alert to instances in which AODA may have recently appeared in response to difficult emotions and situations. Rather than merely addressing AODA, you will also address the

underlying conditions to which the person is reacting. This is similar to what you already do in Partnership, as you help members achieve a good quality of life.

Part III—Agency Implementation Issues

Ensuring a Shared Vision

AODA is an emotional and controversial issue. As discussed above, a shared goal and shared model of AODA can avoid disagreements over personal views. One resistant individual can disrupt an entire infrastructure or agency culture. Leaders must have open communication so that they can be aware of these instances and address them.

If it is recognized that emotions and personal theories are inevitable, then there need be no expectation that people agree to others' emotions or personal theories. Instead, all parties need only agree to the agency's goals of reducing stress and improving outcomes when addressing AODA, and to agree to regard AODA as a chronic health condition similar to diabetes or high blood pressure.

This expectation is clear, simple, and easily measured: Would you act/think/talk this way about a person with another chronic condition who was not adhering to healthcare recommendations?

Conclusion

This chapter discussed the ways in which AODA is an emotional and controversial topic. As with most conflicts, it's always helpful to recognize conflicts as the result of **systems**, not personalities or individuals. Since everyone has been personally affected by AODA and everyone has different personal theories of AODA, people are bound to disagree about AODA. The solution proposed here is that everyone agree to a shared model of AODA—namely, the model of AODA as a chronic health condition. Doing this will reduce disagreements. Since Partnership staff are already experts in addressing chronic conditions, you can expand your expertise to include at least some basic interventions for AODA. The following chapters will explain how to provide those interventions.

Quiz For Chapter 1

Integrating AODA into Long-Term Care

1. Which of the following "traditional" views have been disproved by research and are now rejected by national AODA guidelines?

a. All alcoholics are alike; all drug addicts are alike
b. Aggressive confrontation and shaming is needed to break through denial
c. People with AODA need to be allowed to suffer and hit bottom before they'll change
d. People with AODA lack willpower and/or are immoral
e. All of the above

2. Which of the following is true of chronic health conditions like diabetes, high blood pressure, high cholesterol, and obesity?

a. They are not, strictly speaking, diseases
b. They result completely from people's bad behavioral choices

3. Which of the following are factors involved with chronic health conditions like diabetes, high blood pressure, high cholesterol, obesity, and AODA?

a. Genetic and biochemical factors
b. Environmental factors such as cultural norms, family dynamics, marketing, socioeconomic factors affecting resources
c. Behavioral factors
d. All of the above

4. A doctor says, "Just let him drink himself to death, I don't care." Which model of AODA does this statement reflect?

a. The disease model
b. The moral model
c. The chronic condition model

5. What does the Partnership Program do for chronic health conditions?

a. Early intervention and prevention
b. Require members to follow all treatment recommendations
c. Ask member to let you refer them to a specialist for treatment
d. a and c

6. What do you usually do if a member has not followed a treatment plan?

a. Get angry
b. Discharge them for noncompliance
c. Ask them why, and try to problem solve with the member

7. When a member's chronic condition suddenly gets worse, what do you do?

a. Try to find out what caused the change
b. Blame the member

8. What is one of the things you try to ensure for members with chronic conditions?

a. That they understand their condition and the effects of their behaviors on it
b. That they view us as partners trying to help them, rather than get defensive
c. Both of the above

9. What do you usually do if a particular treatment method does not work?

a. Blame the member
b. Explore why it didn't work
c. Try a different approach
d. b and c

10. Which model of AODA will help Partnership interdisciplinary teams address AODA more effectively?

a. Chronic condition model
b. Moral model
c. Disease model

Quiz Answers:
1 e, 2 a, 3 d, 4 b, 5 d, 6 c, 7 a, 8 c, 9 d, 10 a

Chapter

2

Chapter 2 –Recognizing AOD Problems

Introduction

Chapter 1 acknowledged that **we all have personal theories** about AODA and that **we've all already been personally affected** by AODA, and that community-based long-term care **staff have already been working with**—many would say "struggling" with—AODA issues for years. All of these factors needed to be addressed "up front" **to clear the way for further learning**. Chapter 1 was intended to help you **relax** about AODA, to let go of some of the personal views and histories and to recognize that AODA, as chronic health condition, is not that foreign to your expertise.

In the following chapters, you'll learn how to respond to AOD problems with interventions that are easier for you and more effective with members. Before you can respond to AOD problems, you need to recognize them. Before you're interested in recognizing them, you might need to be convinced that recognizing them is worth your while. Many long-term care staff, especially those working with elders, ask, "Why should I learn about AODA? It's not that common among our members. We only have a few alcoholics; they're the ones with the high costs." This chapter presents some rather striking evidence that AOD problems are usually overlooked, and that "hidden" AOD problems cause more health and social service costs than obvious AODA. Part I of this chapter explains **why** you'll want to recognize AOD problems as soon as possible. Part II explains **what** to recognize, and Part III will teach you **how** to recognize AOD problems.

Part I —WHY to Recognize AODA, the "Silent Epidemic"[23]

Myths:
"It's obvious when someone has a serious AOD problem."
"Only heavy drinking or dependency causes harm."
"If it were a problem, the MD or hospital would have addressed it."

Most long-term care staff have expected AODA to be diagnosed by physicians or at least noticed by healthcare professionals. Most of us think that we'd recognize AOD problems. In fact, research shows that the vast majority of AOD problems are overlooked by healthcare providers, and that the majority of AOD problems (such as falls, accidents, health problems) occur in people who are not AOD-dependent.

Research Evidence

- **70 to 95%** of AOD problems are overlooked by healthcare providers.[24]

[23] From (38)

- **Most** of the problems related to alcohol occur in persons who drink but are not alcoholic.[25]
- "80% of heavy drinkers do not develop significant end organ damage and less than ten percent develop liver failure" (43) (8)
- "Nearly 50% of trauma patients are injured while under the influence of alcohol; however, addressing alcohol problems is not considered a routine component of trauma care" (2).
- Approximately one in four deaths each year is attributable to substance abuse; the rate has almost doubled since 1990. [26]
- Among life-threatening assaults, 84% of the individuals had positive blood alcohol level, and 19% positive cocaine (16)

Among Elders:

*"Substance abuse, particularly of alcohol and prescription drugs, among adults 60 and older is one of the fastest growing health problems facing the country. Yet, even as the number of older adults suffering from these disorders climbs, the situation remains **underestimated, under-identified, under-diagnosed, and under-treated."** (44), emphasis added*

- Over 70% of elders' AOD problems are overlooked by healthcare practitioners (38)
- The second highest rate of hospitalization for individuals 65 and older is for alcohol-related disorders (45)
- The primary factor contributing to falls among Wisconsinites age 65 and over is alcohol (46)
- Hospitalizations related to alcohol are more common than those for heart attacks among elders (47),(38)
- 25 to 50% of nursing home residents have AOD problems (48)
- 21% of elderly hospital patients have AOD problems (38)
- 15% of elders seen in ER (Emergency Rooms) have AODA (38)
- 50% of elderly psychiatric inpatients have AODA (38)
- Functional impairments correlate more strongly to history of alcohol use than to age or to strokes (or to smoking, grip strength, or use of anti-anxiety medications) (49)
- In older women, history of alcohol use doubles ADL functional impairments (49)
- In Wisconsin, 15% of men and 12% of women age 65 and over regularly drink in excess of limits recommended by the National Institute of Alcohol Abuse and Alcoholism (45)
- Alcohol and prescription drug misuse are estimated to occur among at least 17% of older adults{SAMHSA/CSAT, 1998 #269} {Adams, 1996 #47;Atkinson, 1990 #88}

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[24] There are numerous sources for this range of figures, including (29) (10, 39, 40), (41, 42)

[25] Institute of Medicine, Division of Mental Health and Behavioral Medicine. Broadening the Base of Treatment for Alcohol Problems. Washington, DC: National Academy Press. 1990.

[26] Substance Abuse: The Nation's Number One Health Problem, Brandeis University, Schneider Institute for Health Policy, 2001.

People with physical disabilities are **2 to 4 times more likely** to have AOD problems.

- 20 to 40% of people with physical disabilities are heavy drinkers, vs. 10% of general population (50, 51).[27]

People with mental health problems are **over twice as likely** to have AOD problems.

- People with schizophrenia are **over 4 times as likely** to have AOD problems
- People with bipolar disorder are **over 5 times as likely** to have AOD problems
- 46% of suicide attempts among people with MI and AODA were preceded within a few hours by drinking .

"AOD use may conceal a psychiatric disorder, or accelerate its development and magnify its effects. Having either an AODA or psychiatric disorder increases a person's risk of having the other diagnosis. Alcoholics, for example, are:

- 21 times more likely to have an antisocial personality disorder [28]
- 4 times more likely to have a drug abuse disorder
- 6 times more likely to have manic depressive disorder
- 4 times more likely to have schizophrenia" (54)

Trauma and AOD Problems

- 85% of women and 50% of men with co-occurring AODA and psychiatric problems have trauma histories and trauma related symptoms (55)

Depression and Alcohol or Drug Use

"Among co-occurring psychiatric disorders commonly seen in addiction treatment patients are anxiety and mood disorders, post traumatic stress disorder, pathological gambling, sexual and eating disorders in adults and adolescents, and conduct disorders and attention deficit disorder in the latter. Co-occurring addictive disorders commonly seen in psychiatric patients include alcohol, nicotine, opiate, sedative, stimulant, marijuana and hallucinogen abuse and dependence, including dependence on prescription drugs." (54)

- Depression and AOD use involve the same parts of the brain and the same neurotransmitters—serotonin, dopamine, and endorphins.
- Co-occurring depression and alcoholism compared to alcoholism alone results in "poorer psychosocial functioning and spousal relations; increased drinking, arrests, and blackouts; increased risk of suicide; increased risk of relapse to drinking; increased risk of treatment non-compliance and dropout; and more and longer inpatient treatments" (16)

27"People with disabilities are more likely to use substances in part because they experience unemployment, lack of recreational options, social isolation, homelessness, and victimization or physical abuse more frequently than the general population"(51)

28 "Although drug use was found to be associated with various forms of psychiatric diagnoses, it was not found to be associated with any particular form of psychopathology"(52, 53).

- "98% of recently abstinent substance abusers report depressed mood, loss of interest, difficulty concentrating, or anxiety in the past week. Most remit spontaneously…in 4 to 6 weeks" (16)
- People with depression and alcoholism are at higher risk for suicide (56).
- Reducing even low amounts of alcohol –e.g., from 9 drinks per week to 2 drinks per week—improves the effectiveness of antidepressant treatments (57).

Spouses

- "Antisocial personality in one spouse was also associated with anxiety disorders in the other spouse, namely post-traumatic stress disorder in wives and phobia in husbands; similarly, drug abuse/dependence in wives was associated with generalized anxiety in husbands and male drug abuse/dependence was associated with female post-traumatic stress disorder. Dysthymia in wives was associated with generalized anxiety and post-traumatic stress disorder in husbands." (52)

What do all these statistics mean for your daily practice in Partnership?

Since AOD problems are **overlooked by healthcare providers 70 to 95 % of the time**, and since most people prefer not to notice AOD problems, it is **likely** that Partnership staff are also overlooking at least some of members' less obvious AOD problems, especially among the elderly.

Since evidence shows that **even less obvious AOD problems can cause serious harm and costs**, it is **likely** that Partnership members, families, and agencies are suffering the effects of AOD problems far more than necessary. The effects are in reduced health and quality of life and increased health and social services costs. Earlier recognition and interventions could prevent many of these negative outcomes. (29, 30) will tell you what to look for how to recognize AOD problems.

This manual focuses on AOD problems, and does not fully cover mental health practice. It is, however, clear that fully integrated mental health, AODA, and long-term care (health and social services/case management) are needed and are more effective. (11, 58, 59, 60, 61, 62) While a full presentation of co-occurring mental health and AOD problems is beyond the current manual, additional information and resources are provided in the Supplement. Also, since formal AODA treatment does not include tobacco cessation, it is not included in this manual. Resources are widely available on the Internet.

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[29] Interventions effective in improving outcomes are explained in Chapters 3 through 8.

30 The evidence indicates that it is in agencies' interests to notice and address AOD problems. There is a paradox to agency fiscal interest, however. While agency fiscal interest provides motivation for the organization to address AOD problems, agency fiscal interests do not work as a motivation for staff who directly address AOD problems with members. Research from fields of mental health, AODA treatment, mediation/conflict resolution, and systems change indicates that people change best when they are first accepted as they are. If staff judge and resent members for "exploiting" agency and public resources, if staff try to control members to avoid costs, they are set up for failure. Perceiving AOD problems as conflicts of "our fiscal interests versus the member's behavior" will generate power struggles, reactance, frustration, and (usually) failure. Agency managers must be attuned to organizational culture. Honest communication is needed to align and adjust the actual culture to the agency's goals and mission.

Part II—WHAT To Recognize

AODA Diagnoses

Physicians, psychologists, and most AODA practitioners use the criteria for AOD "dependence" and "abuse" found in the "DSM" diagnostic guideline. [31] While not all Partnership staff need to know these diagnostic criteria, health care providers and those who will work with AODA providers will probably want to be familiar with them.[32] They are provided in the Supplement.

Beyond Diagnoses: "Hazardous" and "Harmful" Drinking

There are two major shortcomings with the DSM diagnostic criteria for abuse and dependence. First, they do not work well for elders. The diagnostic criteria for abuse and dependence look for AOD use despite legal, family, social, or work problems. But elders often have reduced family and social roles (e.g., they are more isolated, drive less, and do not work), so they have fewer problems in those spheres. Many elders with AOD problems would not be recognized using the DSM diagnostic criteria.[33]

Second, there is increasing evidence that **some 80% of increased healthcare costs resulting from AOD use occur in people who fail to meet the DSM criteria for abuse or dependency**.[34]
Most auto accidents, falls, violent acts, crimes, suicides, and alcohol effects on fetuses follow consumption of alcohol in people who do not meet DSM criteria for alcohol abuse or dependency.
In response to this evidence, the World Health Organization developed a categorization system to recognize these harms and risks, even if the threshold for abuse or dependency is not met. This newer categorization system recognizes lower-level drinking that is problematic, even though it falls short of the DSM diagnoses of abuse or dependency.[35] This new categorization system can be used along with or instead of the DSM diagnoses. Before explaining the new categorization system, it is first necessary to **define a standard drink** and recommended drinking limits.

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[31] Diagnoses are made using the "DSM-IV-TR"-- the Diagnostic and Statistical Manual, 4th edition, Text Revised, which covers psychiatric diagnoses. Sometimes physicians use the "ICD-10" diagnoses codes; ICD-10 stands for International Classification of Diseases, 10th edition. DSM and ICD-10 diagnostic criteria are provided in the Supplement.
[32] Understanding the DSM diagnostic criteria will help you interact more knowledgeably with AODA providers and health professionals who use them.
[33] For a more in-depth critique of diagnostic criteria relative to elders, see SAMHSA TIP #26. (38)
[34] Institute of Medicine, Division of Mental Health and Behavioral Medicine. Broadening the Base of Treatment for Alcohol Problems. Washington, DC: National Academy Press. 1990.
[35] "The last 20 years have seen a significant paradigm shift in how we view alcohol misuse. The dichotomous model of "alcoholism" and "normal drinking" has now been replaced by the concept of a spectrum of disorders…." (63).

Federal guidelines define **a "standard drink"** as the following:

DEFINITION OF A "STANDARD DRINK
1.5 oz shot of vodka, gin, whiskey, etc.
12 ounces of beer
5 ounces of wine
12 oz wine cooler
4 oz. of sherry, liqueur, or aperitif

Federal guidelines define **recommended drinking limits** as follows:

	Max # of Standard Drinks Per Occasion	Max # of Standard Drinks Per Week
Men under age 65	3 or 4	14
Women under age 65	1 or 2	7
Men over age 65	1 per usual day; up to 2 drinks on special occasions [36]	7
Women over age 65	1	"Somewhat lower limits" than for men" (38)

The new categorization system identifies drinking as **"low-risk," "hazardous"(also called "at-risk"), "harmful" (also called "problem") drinking, and "dependence."** Most AODA experts consider use of any illegal drug to be harmful use, so this categorization system is usually applied only to alcohol.

"Low-Risk" drinking is drinking

- No more than 1 or 2 drinks per occasion,
- No more than up to 3 times a week, **and**
- **Never** if there is risk of harm to self or others (e.g., driving, pregnancy)

"At-risk" or "hazardous" drinking is drinking in which no problems have been caused yet, but the person drinks:

- Above the maximum recommended amounts, **or**
- In high-risk situations. (This can include <u>small</u> amounts of intake, if there is risk of harm—for example, during pregnancy or with certain medications or health conditions or very old age.)

"Harmful" or "Problem" Drinking

Problem drinking is drinking despite negative consequences to self or others. This **does not have to be heavy** drinking. Examples of harms include accidents or injuries, blackouts, legal

[36] Special "drinking occasions" such as New Years' Eve, weddings. (38)

problems, high-risk sexual behavior, interpersonal problems including with one's children, family, or partner.

"Harmful drinking" essentially means the same thing as "abuse." "Abuse" is an emotive (emotional) term because it's often used with "child abuse," "domestic abuse," etc. As such, the term "abuse" may generate defensiveness and resistance from the person so labeled, which can be counter-productive for you. "Harmful" use focuses on the consequences of the use, even if the person drinks only small to moderate amounts and even if they're unaware that the alcohol is causing problems. Many elders, and other members with multiple health conditions and medications, are not even aware that their drinking could be causing risk or problems.

"Dependence"

"Dependence" is the same as "addiction" or, in the case of alcohol, "alcoholism." Dependence is defined as **loss of control** during use and/or **difficulty cutting back or quitting**. Dependence usually includes "harmful" or "problem use" (usually with lots of problems) **and** loss of control of use or difficulty cutting back. Difficulty cutting back includes:

- Loss of control while drinking/using, despite intentions to only have low intake
- Relapse potential: Can't follow through with plans to cut back
- Physical dependence: Withdrawal symptoms if cut back or stop
- Psychological compulsion: Think about it, schedule life around drinking

"Heavy" and "Binge" Drinking

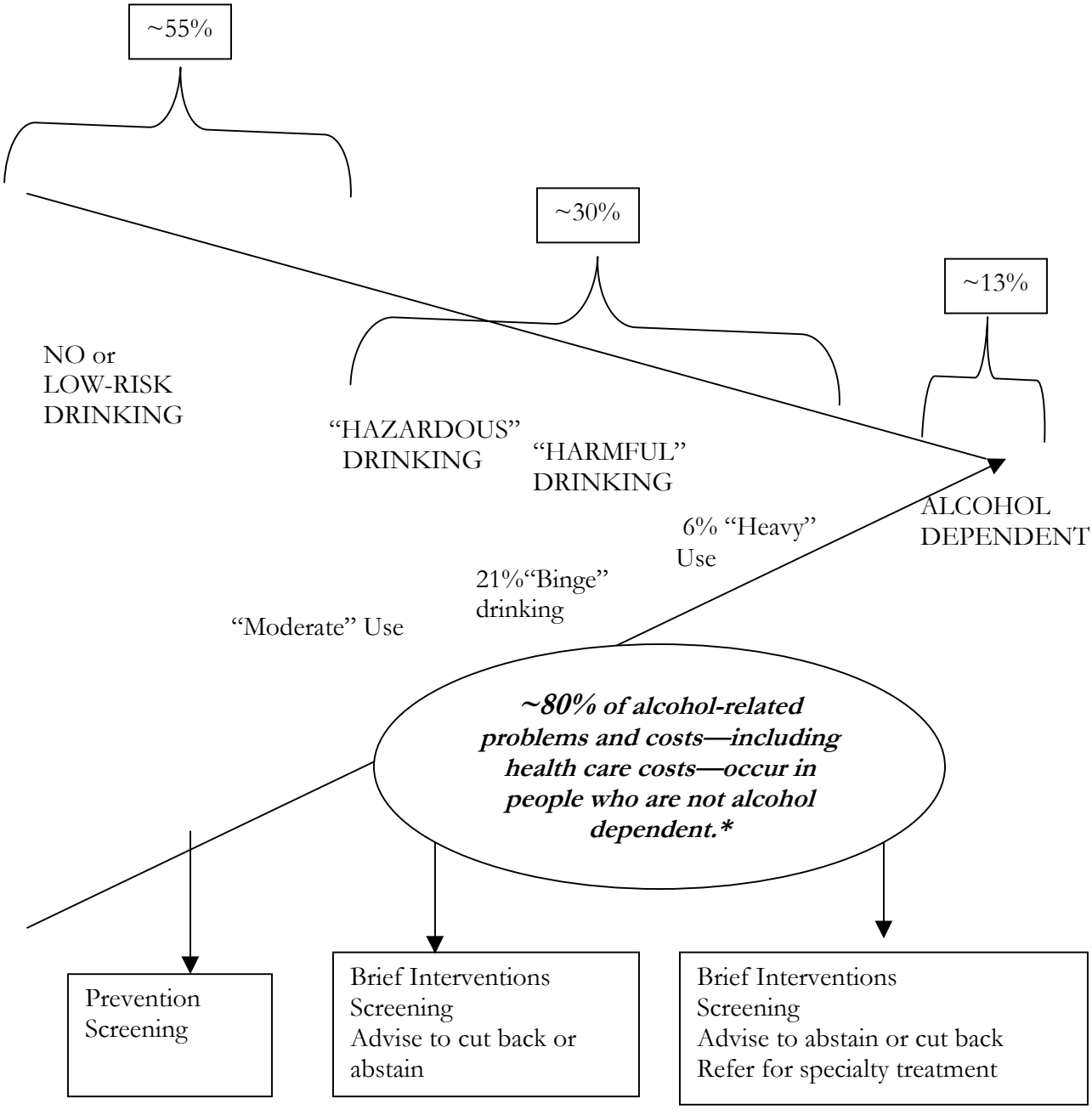
Some AODA authors also use a category of "heavy" drinking. "Heavy drinking" is an additional category not captured in the DSM diagnoses. Heavy drinking is defined as drinking above the recommended limits. Infrequent heavy drinking is called "binge" drinking.

"Heavy drinking" can be a handy description of someone's use, but it is not really necessary as a **category**. Heavy drinking would fall in the **hazardous** category if no harms have occurred yet, and in the **harmful** drinking category if harms have already occurred. In either case, the feedback and interventions are essentially the same. In either case, dependence is determined by whether the person has loss of control of use and/or difficulty cutting back or abstaining.

"Binge" drinking is defined as more than 5 standard drinks per occasion for men and more than 3 for women.

U.S. ADULTS IN EACH DRINKING CATEGORY

This is only a schematic with very general percentages compiled from numerous federal websites and publications (particularly those on Brief Interventions) listed in bibliography. Many individuals are in different drinking categories at different times in their lives.



* Institute of Medicine, 1990. Broadening the Base of Treatment for Alcohol Problems.

The categories are not discrete, or black and white; they are a continuum and they overlap. Partly because the disease model defines alcoholism as "primary, progressive, and fatal," it was previously thought that people made a **linear progression** from abuse to dependence, and that **most** people with hazardous drinking would progress to dependence. The evidence disproves both of these assumptions. Only a small minority of people with hazardous or harmful drinking later become alcohol-dependent. (34) And alcohol use often varies over the lifespan. Bingeing and heavy drinking are heaviest among young adults, decreasing significantly by age 25. People with alcohol problems often cut back or quit after only a few risks or problems occur, without progressing to dependence and without ever getting AODA treatment.

In other words, this broader categorization of drinking exposes what was previously overlooked in the traditional view of alcoholism as primary, progressive, and fatal disease—namely, that people are in the various drinking categories at different times in their lives. There is not a sharp line between alcoholics and "normal" (as in risk or problem-free) drinkers. It's a matter of degree, and it can change year to year, month to month. (Recalling the statistics of U.S. adults' AOD use from Chapter 1, there is not a sharp line between "alcoholics" and "us" helpers, either.) Some advocates even reject the view of AOD use as pathological at all: Use of mood-altering drugs has been a universal and often beneficial aspect of human life for millennia. People with AOD problems are not sick or pathological; they just need some help regaining balance in their lives. This is understandably a minority view in the AODA treatment field, but it's worth considering in long-term care, where a strengths-based, rather than deficits-based, model has been recommended for some years. Recognizing these broader categories of use along a spectrum, and people's mobility among the categories, can make you feel less hopeless about "alcoholics." You'll learn in Chapter 4 and 5 that just 10 to 20 minutes brief interventions can encourage people to cut back from hazardous or problem drinking, even dependency, to reduced risk or no use.

Risks—Sooner or Later

People tend to naturally care more about immediate risks than future risks. When discussing risks, it is helpful to distinguish risks as in the near or remote future. For example, younger adults tend to care very little about long-term health effects. They tend to be more receptive to concerns about immediate risks. Getting drunk has acute risks from violence, injuries, or unsafe sex that can be very high. It is often more effective to focus on immediate risks than remote harms, so do talk about these risks with members.

Part III – HOW To Recognize AODA Problems

There are **two general ways** to recognize AOD problems that might otherwise be overlooked. The first is "AODA screening," similar to cholesterol or blood pressure screening. The second is to notice hints (or "red flags") of possible AOD problems.

AODA Screens

AODA screens are brief questionnaires meant to find people who might have an AOD problem or dependence. The most commonly used screens have fewer than 10 questions and can be done by anyone, with no special training necessary.

Screens are designed to be **helpful** (not perfect) to **sort populations** of **strangers** into those who "probably don't" versus those who "probably do" have AOD problems. Talk of populations and probability reveal the limitations of AODA screens:

1. Screens are NOT always accurate for an individual [37]
   Screens can have "false positives" and "false negatives."
   Screens can be even **less** accurate with certain populations: women, various cultural groups, elders, dual diagnoses, etc. *(For details see Supplement.)*

2. Screens are not as accurate as you really getting to know the member and understanding details of what and why they drink/use and the problems it might create.
   One Wisconsin study showed that case manager's impressions were the most accurate predictors of AOD problems among clients with mental illness. (62) This is not true for elders, whose AOD problems are usually overlooked (45, 65, 66)

3. Most AODA screens were designed to find AOD abuse and dependence, but not hazardous use. So those screens overlook the majority of AOD problems. Fortunately, evidence shows that simply adding quantity and frequency questions will capture most hazardous and harmful drinking patterns.

These are the limitations of AODA screens. So why should you bother with them at all?

- Because they can help you find AOD problems when you don't suspect them.
- Because evidence indicates that the majority of AOD problems are not suspected. As with other chronic conditions, screening can promote prevention and early intervention.

So how should Partnership staff use screens?

- As part of the intake process
- As memory joggers—reminders of the kind of questions you can ask members, family members, or anyone to help identify possible AOD problems

Example Of A Screen

A commonly used screening method is to add quantity and frequency questions to the "CAGE" questionnaire. The CAGE on its own is only mediocre,[38] but combined with quantity and frequency questions, it is more accurate. (10, 45, 67) It is demonstrated here because many of you are already familiar with CAGE. CAGE-AID is simply the CAGE questions with "other drugs" added.

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[37] One noteworthy study showed that objective scores on the Addiction Severity Index (another very popular screen) did not correlate with clinicians' subjective impressions **or clients' own narratives about their AOD problem** (64).

[38] For more detailed analysis of particular AODA screens, see Supplement.

The CAGE Questionnaire:

- Have you ever felt you should **C**ut down on your drinking &/or drug use?
- Have you ever felt **A**nnoyed at others' criticisms of your drinking &/or use?
- Have you ever felt **G**uilty from anything after drinking/drug use?
- Have you ever had an "**E**ye-opener"—a drink in the morning?

Quantity & Frequency Questions

- How much alcohol do you drink in an average week? (How much do you use of each drug?)
- How many days a week do you drink/use?
- How much do you drink/use at a time?

  or
  - What's the least you'll drink at a time? What's the most you'll drink at a time?[39]

  or
  - How often do you have more than 3 drinks at one time? (How many times in the past month have you?)

Remember to clarify what you mean by "a drink" and what the member means by "a drink"!

What Is A "Positive" Screen?
A positive AODA screen is an indication that the person is likely to have an alcohol problem.

CAGE + Quantity/Frequency Screen is "Positive" if

- 1 or more "Yes" answers to the "CAGE" —**C**utting down, **A**nnoyed, **G**uilty, or Eye-Opener

or

- Quantity/frequency exceeds:

  14 drinks/week or 4 drinks/occasion for men < age 60
  7 drinks/week or 3 drinks/occasion for women < age 60

Dependency is probable if any of the following is true:

- CAGE score is 3 or 4
- Impaired control of drinking
- Compulsion to drink, difficulty quitting
- Withdrawal symptoms when person cuts back or quits

[39] Research shows that people are more honest with "minimum-then-maximum" questions than with "How much do you drink?" question. This might be because the minimum is asked and accepted nonjudgmentally first, which "paves the way" for the maximum to be stated truthfully. (Bohn, 1998)

This is just an example of a screen. For more details and examples, see optional documents on AODA screens in the Supplement.

"RED FLAGS" for Alcohol Problems

Sometimes AODA screens will be your first indication that someone might have an AOD problem. Other times there will be some other indication. If you learn to watch for things that might be caused by AOD problems, you'll be able to intervene earlier, before problems get worse. Your interventions will be much more on target as well, and so more effective, than if you overlook AOD as a factor.

None of these "red flags" **prove** AOD problems. Instead, they are just **hints** that there **might** be an AOD problem. When you notice these red flags, you should consider whether AOD use might be involved. The vast majority of AOD problems are not recognized as AOD-related. By noticing these red flags, you can provide effective early intervention and prevention.

Many of your members may be completely unaware that alcohol or drugs might be causing or worsening these problems. **Hazardous or harmful drinking can occur even with only moderate use.** Hazardous or harmful drinking does not require that the person is alcohol dependent, or even that they're a heavy drinker.

Indications of possible use of cocaine, speed, and other street drugs are included in the Supplement.
Recognizing and responding to misuse of prescription medications, particularly when pain or anxiety is involved, is covered in Chapter 10. Following are some "red flags" that should make you look for possible **alcohol** use:

"Red Flags" to Consider Alcohol Use[40]

- Poorly controlled hypertension[41] or diabetes
- Difficulty in adjusting doses of Coumadin (or warfarin, a "blood thinner" used to prevent blood clots that cause strokes or heart attacks)
- Falls, injuries, accidents
- Family/ relationship problems, victimization, violence, abuse
- Depression, anxiety, suicidal ideation, and other mental health problems
- Sleep disturbance
- Headaches
- Sexually transmitted diseases
- Urinary incontinence

[40] These lists are compiled from (38), (47), (51, 68)
[41] Heavy alcohol use is the most common cause of secondary hypertension (MacMahon, 1987), with a 10 to 30% prevalence in men. "Alcohol-induced hypertension appears reversible with abstinence (Klatsky 1990)" in (43) Module 6, p.3)

- Gait disturbances
- Impaired immune system and capability to combat infection and cancer
- Osteoporosis (decreased bone density)
- Chronic abdominal pain, gastrointestinal disturbance
- Malnutrition
- Cognitive impairments, memory lapses, or dementia
- Cirrhosis and other liver diseases, pancreatitis
- Seizures
- Withdrawal symptoms mistaken for other illnesses *See Withdrawal in Supplement*

The following are red flags for alcohol problems **and/or depression:**

- Lack of self-care—hygiene, health management
- Apathy, poor eye contact
- Frequent crying
- Dehydration
- Decline in cognitive or physical abilities, slurred speech, poor coordination
- Hopelessness, despair, negative views of self and of life

These are long lists of problems that **might** indicate alcohol problems; they are not proof of AOD problems.

To summarize:
You'll ask AOD screen questions anytime you meet a new member, whether or not "red flags" are present.
You will be alert for—will not overlook—"red flags" that <u>may</u> indicate AOD problems. (Direct care workers, drivers, day-center aides, etc. can be invaluable "extra eyes and ears" if they are taught what to look for and to whom to report these signs.)

When a screen is "positive" <u>OR</u> "red flags" are noticed, you'll respond as explained in Chapters 4 and 5. ("Red flags" for other drugs are provided in the Supplement.)

Recognizing Risks for Alcohol Withdrawal

Knowing whether someone is at risk for withdrawal from alcohol or other drugs can be difficult. The symptoms are at first subjective and vague and can be caused by many different conditions and medications. Alcohol withdrawal is potentially lethal if not carefully treated; mortality is 15% in untreated patients. (69). Three somewhat reassuring points:

1. The severity of alcohol withdrawal correlates with—can be predicted from—the amount the individual has been drinking. With the heaviest drinkers, this is usually known.
2. Alcohol withdrawal has a gradual onset. Symptoms appear gradually 6 to 25 hours after the last drink (or abrupt reduction in intake) and worsen over a few days. Only 5% of patients hospitalized for alcohol withdrawal develop delirium tremens (70)
3. The symptoms can be managed once they become evident.

The most important point here is to assess for potential withdrawal and take preventive steps if the person will have reduced intake. Consider this, for example, whenever a member is about to be admitted to a hospital, nursing home, or group home where access to AOD will be cut off.

While there is no evidence that elders are more prone to withdrawal, withdrawal may be more severe in elders. (57) Medical co-morbidities and complications often seen with withdrawal:

Pneumonia
Coronary disease
GI bleeding
Dehydration
Delirium

It is important to have an MD with expertise in treating withdrawal in elders. For example, elders should be given short-acting benzodiazepines rather than longer-acting Valium (which is usually given for withdrawal).

The next pages explain the signs and symptoms of alcohol withdrawal. This is the "Clinical Institute Withdrawal Assessment for Alcohol, Revised." (71) Everyone should read the CIWA to learn the basic symptoms of alcohol withdrawal. It's important that everyone is able to recognize and report these symptoms to an RN, NP, or MD. RNs, NPs, and MDs should study it more closely so that you can incorporate it into care planning. (57)

ADDICTION MEDICINE ESSENTIALS

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

Many quantification instruments have been developed for monitoring alcohol withdrawal (Guthrie, 1989; Sullivan et al, 1989; Sellers and Naranjo, 1983). No single instrument is significantly superior to the others. What is clear is that there are significant clinical advantages to quantifying the alcohol withdrawal syndrome. Quantification is key to preventing excess morbidity and mortality in a group of patients who are at risk for alcohol withdrawal. Such instruments help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages, such as *delirium tremens*. By intervening with appropriate pharmacotherapy in those patients who require it, while sparing the majority of patients whose syndromes do not progress to that point, the clinician can prevent over- and undertreatment of the alcohol withdrawal syndrome. Finally, by quantifying and monitoring the withdrawal process, the treatment regimen can be modified as needed.

The best known and most extensively studied scale is the Clinical Institute Withdrawal Assessment - Alcohol (CIWA-A) and a shortened version, the CIWA-A revised (CIWA-Ar). This scale has well-documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians (Knott, et al, 1981; Wiehl, et al 1994; Sullivan, et al, 1989). From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA-Ar (Wiehl, et al, 1994). It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings, including detoxification units (Naranjo, et al, 1983; Hoey, et al, 1994), psychiatry units (Heinala, et al, 1990), and general medical/surgical wards (Young, et al, 1987; Katta, 1991). The CIWA-Ar has added usefulness because high scores, in addition to indicating severe withdrawal, are also predictive of the development of seizures and delirium (Naranjo, et al, 1983; Young, et al, 1987).

The CIWA-Ar scale can measure 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores of 8 to 15 indicate moderate withdrawal (marked autonomic arousal); and scores of 15 or more indicate severe withdrawal (impending *delirium tremens*). The assessment requires 2 minutes to perform (Sullivan, et al, 1989).

CIWA-Ar categories, with the range of scores in each category, are as follows:

Agitation	(0-7)
Anxiety	(0-7)
Auditory disturbances	(0-7)
Clouding of Sensorium	(0-4)
Headache	(0-7)
Nausea/Vomiting	(0-7)
Paroxysmal Sweats	(0-7)
Tactile disturbances	(0-7)
Tremor	(0-7)
Visual disturbances	(0-7)

The instrument also has been adapted for benzodiazepine withdrawal assessment (Clinical Institute Withdrawal Assessment-Benzodiazepine).

A study of the revised version of the CIWA predicted that those with a score of >15 were at increased risk for severe alcohol withdrawal (RR 3.72;95% confidence interval 2.85-4.85); the higher the score, the greater the risk. Some patients (6.4%) still suffered complications, despite low scores, if left untreated (Foy, et al, 1988).

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Clinical Insitutue Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

Part IV—Agency Implementation Issues

Given the evidence of the extent of AOD problems and the extent to which they are overlooked by healthcare providers, it seems clear that Partnership agencies will not want to depend on healthcare providers to diagnose AOD problems. Instead, agencies will want to establish more proactive approaches to discerning "hidden" AOD problems among their members. Agencies could consider providing basic training to anyone who sees or talks with members, to increase the perception and reporting of possible AOD problems. This includes unlicensed assistive personnel.

Some intake staff (those who do initial assessments as part of the enrollment process) said that they feel pressure to "find out for sure" if a new member has AOD problems, so that this factor can be considered in assigning an interdisciplinary team.[42] Sometimes this sense of responsibility toward interdisciplinary teams made intake staff think they must get the new member to recognize their AOD problem; this is not the case, as Chapters 4 and 5 will explain. Given the evidence, it is clear that AODA screening should be incorporated into the general health assessment done by intake staff. How intake staff (and others) should respond to the results of screens and to other indications of possible AOD problems are explained in the following chapters.

Conclusion

This chapter presented evidence that AOD problems are **usually overlooked**, and that "hidden" AOD problems cause more health and social service costs than obvious AODA. The criteria for diagnoses of abuse and dependence are provided in the Supplement. For alcohol, an alternative categorization system of low-risk, hazardous (or "at-risk"), and harmful (or "problem") drinking is now preferred, as it is more precise and allows for earlier intervention and prevention for many more people. AODA screens will help you discover hidden AOD problems, but quick recognition of "red flags" is the most effective way to promote earlier interventions and improved outcomes.

Later chapters will explain how you can respond after you notice AOD problems. Chapters 4 and 5 will present specific interventions for AOD problems. Before looking at those, however, Chapter 3 discusses a more general response—harm reduction—that will apply to people who refuse to discuss their AOD problems, those who are cutting back or abstaining, and those who don't even have AOD problems. The response is the general approach of attempting to ensure people's safety no matter what their behaviors are. This is already a part of your normal practice. Because attempting to reduce harm might be all you can do with people with the most harmful AOD use, it is discussed first, before going into more specific AODA interventions.

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[42] The perception that people with AOD problems require more staff time and have higher service utilization is born out by preliminary AODA data obtained from the Partnership agencies. See the full report in the Supplement.

QUIZ FOR CHAPTER 2

1. According to research, what percentage of AOD problems are overlooked by healthcare providers?

a. 10 to 20%
b. 70 to 90%

2. The majority of healthcare expenditures resulting from AOD problems occur in:

a. People who are alcohol- or drug- dependent
b. People who are not alcohol- or drug-dependent

3. What is one of the fastest growing health problems facing the country?

a. The SARS virus
b. Elders' misuse of substances, especially alcohol, tobacco, and prescription drugs
c. Diabetes

4. What are the recommended drinking limits set by U.S. Dept. of Health & Human Services?

a. Under age 65: 14 standard drinks per week for men, 7 drinks per week for women
b. Under age 65: No more than 4 drinks per occasion for men or 3 drinks per occasion for women
c. Over age 65: No more than 1 standard drink per occasion, unless health conditions or medications indicate that any alcohol would be harmful
d. All of the above

5. Heavy drinking can place an individual in which drinking category?
a. Low-risk drinking
b. Hazardous drinking (if no problems have occurred yet)
c. Harmful drinking (if some problems have occurred)
d. Alcohol dependency (if person loses control or has difficulty quitting)
e. b, c, and d

6. Which of the following is/are true about AODA screens?

a. They are helpful in sorting populations of strangers, to find those likely to have AOD problems
b. They are not as accurate as knowledge about an individual's drinking or drug use
c. They are 100% accurate, and so they are all we need to do
d. a and b

7. Which of the following are “red flags” that should make you explore whether alcohol or drugs may have been involved?

a. Chronic abdominal pain, gastrointestinal disturbance
b. Gait disturbances, falls, injuries, accidents
c. Decline in cognitive or physical abilities, slurred speech, memory lapses, depression
d. Sleep disturbances, headaches
e. All of the above

8. Which Partnership staff may be the first ones to notice or be told by members about the conditions listed in 7?

a. Personal care workers
b. Any staff who chat with members while doing their work
c. a and b

9. Which of the following indicate that the person may be alcohol dependent?

a. Drinking alcohol in the morning
b. Loss of control while drinking; drinks more than intended
c. Difficulty cutting back; compulsion to drink
d. Withdrawal symptoms when cuts back
e. All of the above

10. Hazardous or harmful drinking in elders or people with certain health problems or medications can occur:

a. Only when drinking above the recommended limits
b. Even when drinking small to moderate amounts

Quiz Answers:
1 b, b, 3 b, 4 d, 5 e, 6 d, 7 e, 8 c, 9 e, 10 b

Chapter

3

Chapter 3–Harm Reduction

Introduction

Reducing harm is what you already do in human services and healthcare, just by trying to help people.
Your service plans are made in order to reduce risks of harm, both immediate and in the future. You help people manage their health conditions to try to prevent harm. You provide immunizations to reduce the harm from elders getting the flu. You do home safety assessments to reduce risk of harm.
Some might say that social services and healthcare services are fundamentally about reducing harm.
As one addiction physician put it,

> *"The practice of medicine IS the practice of harm reduction. It is a fundamental principle of medical care that the patient has the right to disagree, to be non-compliant, to choose a path or a goal other than the one we might desire for them. The physician's job is to do everything possible to help such a patient do the best he can, to minimize harm since, at least temporarily, it cannot be eliminated…. This is harm reduction. We accept the refusal or inability of the patient to do the best thing, and try our hardest to do the next best thing."*[43]

Harm reduction is whatever you can do to reduce risks or harm, no matter what the member does. Your acts to reduce harm vary from helping a member walk without falling to reporting a pharmacy error, establishing a back-up plan in case workers don't show up, to providing a commode or a personal emergency response system (e.g., "Lifeline").

In the context of addressing AODA in Partnership, harm reduction is only part of what you will do.
You will learn specific interventions for AODA in Chapters 4 and 5. But because the most difficult situations Partnership staff have involve members (or families) who continue with harmful AOD use, reducing harm is addressed first. Sometimes reducing harm is almost all you can do.

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[43] Alexander DeLuca, M.D., FASAM, http://www.doctordeluca.com/Library/AbstinenceHR

There are two ways in which reducing harm can become controversial. These two ways are discussed next.

Part I —Harm Reduction Meets Standards of Practice

Sometimes particular ways to reduce harm can seem to conflict with professional standards of practice, most often for healthcare providers. Healthcare practitioners and in fact any human service providers often have more restrictive standards of practice and tolerance for risk than people do in everyday life.
For Partnership, in which most members live in the community, these differing tolerances for risk can lead to conflicts. For instance, do professional standards of practice allow a physician or nurse to adjust a member's medications on the weekends because the member smokes marijuana then?

The goal is to reduce the risk of adverse medication interactions. The healthcare professionals must ensure that the member is making a **fully informed choice** to use marijuana despite that risk. They must have advised the member not to smoke marijuana given those risks. If these things have been done, and the member will still smoke marijuana, then adjusting the prescribed meds to reduce the risk of harmful interactions is a form of harm reduction that is appropriate in this case. Such decisions involve a **balancing** of particular factors and the relative severity and likelihood of various harms. For instance, if the member is likely to have bad seizures if seizure meds are reduced, then seizure meds should probably not be reduced. Each decision must be based on the individual circumstances. Let's look at a few more examples of harm reduction involving AODA.

Examples of Doing Harm Reduction

As noted above, harm reduction is only part of your response to AOD problems. The other responses are explained in Chapters 4 – 7. For now, assume that each of these members has already been given feedback about the harms caused by their AOD use, and they've already been advised to quit or cut back. They've already had various treatment options explained to them, and they've already refused AODA treatment. They may or may not have agreed to cut back, but they are definitely still using AOD.
You will continue to provide AODA interventions (described in later chapters), but at the same time you can also do harm reduction as illustrated below.

> ***Clarence*** *is a 77 year old who's been alcohol dependent since his teens. He's had no periods of sobriety in his life. He's been through jail and detox dozens of times, and rehab several times. Clarence has his first drink around 10 a.m. after he gets up. Clarence's usual pattern is to have a shot-glass of whiskey about every two hours. His nutrition is extremely poor, and his weight has dropped from 180 to 130 pounds in the past month. He's refused AODA treatment, and refused to cut back on his whiskey. He says, "People said the whiskey would kill me before I was 20, and here I am 77. I know I don't have much longer to live. I'm not cutting down now. I'm happy enough here, just let me be."*

Ideal Goal: Clarence enters AODA treatment and never drinks alcohol again.
Harm Reduction Until Ideal Goal Can Be Met
Since his nutrition is so poor and his weight is dropping so fast, Clarence's Partnership staff contracted with him, that every time he takes a shot of whiskey, he'll drink a can of nutritional milkshake or eat a peanut butter sandwich (which he loves). Clarence agreed to do this. He regained 14 pounds within 6 weeks.

Tilly *is a petite 88 year old with a long history of alcohol use, at times heavy; it appears she is an alcoholic, but information is scanty and Tilly is not a good historian. Tilly has been losing weight rapidly. Her fluid and nutritional intake are dangerously low. She has advanced directives and refuses a feeding tube. She's been thoroughly assessed and does not have depression or any medical causes for her poor appetite. Tilly's daughter tells you that the only way to get her to eat and drink more is to give her a little alcohol.*

Ideal Goal: Tilly has normal nutritional and fluid intake and never drinks alcohol again.
Harm Reduction Until Ideal Goal Can Be Met
Tilly's Partnership team decides that since Tilly will soon die if she does not eat and drink more, and since there is no treatable cause determined for her poor intake (such as depression), her daughter's method may be a justified method of harm reduction. The RNs and NPs (nurse practitioners) worry that it violates professional standards to give alcohol to an alcoholic. The pros and cons of Tilly's unique situation, however, and the fact that all parties (including Tilly and her daughter) agree, support this method of harm reduction for Tilly right now.

A little rum is added to Tilly's nutritional milkshake, and she drinks it all, 3 times a day. With a little watered-down wine at dinner, Tilly eats a full meal. Her nutritional and fluid intakes are soon normal, and she regains weight. Her energy is better and she's more talkative and smiles more. Everyone considers this a success.(72)

Bob has caught his mattress on fire twice from smoking in bed. It turns out this only happens when he's been drinking heavily, which he only does on Saturday. The rest of the time, Bob doesn't smoke in bed, because "I know it's stupid and dangerous."

Ideal Goal: Bob enters AODA treatment and never drinks alcohol again. He also quits smoking.
Harm Reduction Until Ideal Goal Can Be Met
You try problem solving with Bob. It's clear that once he's drunk, he's not likely to keep any promises such as not smoking in bed. Bob comes up with the idea that solves the problem:
Option 1:
Bob always drinks with his buddy, whose wife never drinks. When he's drinking, he'll sleep on their couch, and his friend's wife will take his lighter and cigarettes before bedtime. In exchange, he'll cook them brunch. They agree.
Option 2:
Since Bob only drinks on Saturdays, he makes an arrangement with a friend that at 9 p.m., he'll have his last cigarette and give the rest, and his lighters, to his

friend to hold. (This is a friend who does not get drunk.) Bob tells his buddies of this plan, so that everyone knows about it and won't give him any cigarettes.

Celia has some cognitive and physical limitations from a brain injury, but is legally competent and her own guardian. Celia's father was an alcoholic and she has a history of blackouts and harmful drinking. Her major social circle now is the small neighborhood bar. People there are good to her. Most of the time Celia has no more than 2 drinks an evening, and goes home by 9:00. Occasionally, on Friday or Saturday, if a handsome newcomer comes in, Celia loses control of her drinking and gets drunk and flirtatious. She is then very vulnerable to unsafe sex, violence, etc. Celia needs AODA interventions (as described in later chapters), which you and others are providing. She is not yet willing to quit, so some immediate steps for harm reduction are needed. Here are some ideas that might help Celia be safer until she quits:

Ideal Goal: Celia enters AODA treatment and never drinks alcohol again.
Harm Reduction Until Ideal Goal Can Be Met:

Option 1:
Celia stays out of the bar on Fridays and Saturdays. You help her think of other things to do then, and you provide whatever supports she needs. You provide her transportation to go stay at her sisters' some weeks; other weeks you help her arrange to go out to movies and other alcohol-free places with friends.

Option 2:
Celia goes to the bar but drinks only one drink; all the rest are non-alcoholic drinks. Because Celia loses control once she's started drinking, this plan is unlikely to work without help from others. Surprisingly, the owner/bartender and several of Celia's friends at the bar agree to help her with this. Not only will the bartender avoid serving her alcohol; he and the friends agree to intervene if Celia tries to drink others' drinks, and to prevent her from leaving with men.

Part II — Harm Reduction as AODA Treatment

Part I discussed harm reduction in the general sense of negotiating ways for a member to reduce risk or harm even while still using alcohol or drugs. The term "harm reduction" has another, more specific, meaning as well. Harm reduction in AODA is an "umbrella" term for various stances, but is generally a model with the following premises[44]:

Harm Reduction Model	"Traditional" Abstinence-Based AODA Treatment
Strengths based	Problem oriented
Collaborative, flexible	Authoritarian, rules-based
Goals set by the person (consumer-centered)	Goals set by program/ professionals
Accepts gradual reduction, celebrates any positive steps (i.e., tolerates non-abstinence)	Abstinence is required for treatment
Success is improved outcomes, including quality of life & well-being (even if not abstinent)	Success is abstinence from all mood-altering substances

[44] (73, 74, 75)

Harm reduction was originally associated with needle-exchange programs (to reduce HIV and hepatitis among IV drug users), and later associated with the very controversial "moderated drinking" movement.[45] Harm reduction is often construed as anti-abstinence, engendering critiques that it encourages destructive lifestyles and denies the reality of AOD disease and addiction.[46] But harm reduction also promotes all of the following which have shown to reduce levels of intoxication and harms from alcohol: higher legal drinking ages, stricter drunk driving laws, "drunk-proof" automobiles (e.g., breathalyzer ignitions, coded door locks), restrictions on liquor sales, provider (alcohol sellers and servers) liability laws, taxation and price increases, local community control (e.g., zoning, permits), rejection of targeted marketing (e.g., in poor or Black neighborhoods), reduction of drink promotions (e.g., 2-for-1 drinks), and environmental changes of, e.g., the alcohol content of mixed drinks and the availability of food at bars (76).

Harm reduction is basically a **public health** approach, in that it seeks to assist the vast majority of people with risky or harmful drinking—not only the relatively few who are alcohol-dependent. In the AODA field, harm reduction remains controversial because it tolerates non-abstinence, thus upturning the longstanding model of AODA as a progressive disease whose only cure is abstinence.[47]

> *"In sharp contrast to the insistence of disease model and Twelve-Step programs that abstinence be the "First Step" in dealing with all alcohol problems, harm reduction encourages a gradual, "step-down" approach to reduce the harmful consequences of alcohol or drugs. When the harm is reduced incrementally, drinkers can be encouraged and supported to pursue proximal subgoals along the way to either moderation or abstinence. Clearly, the "just say no" message no longer applies for people who have already said "yes." In these cases, harm reduction provides answers to the next question: "Just say how?" Harm reduction offers a realistic and compassionate alternative to the prevailing abstinence-only or zero-tolerance policies derived from the traditional disease model." (76), p. 109-110*

Harm reduction is increasingly being promoted as strategy to use **pending** abstinence, with abstinence always the desired goal for AOD dependency. Harm reduction as an AODA treatment model does **not** mean you should ignore AOD problems. Harm reduction is **not anti-**

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[45] Proponents of "moderated" or "controlled" drinking assert that alcohol-dependent people do not need to abstain; they can instead learn to drink in moderate amounts. Since for many people a key component of dependency is lack of control while drinking, this is a highly criticized position.

[46] Several harm-reduction workers who were young heroine addicts died from accidental overdoses shortly after presenting at harm reduction conferences. Tragedies such as this only add to critiques that harm reduction promotes destructive lifestyles.

[47] In part, harm reduction as AODA philosophy can be viewed as a "glass half-empty or half-full" shift in perspective. In the disease model, people who were not abstinent were treatment "failures," and all treatment (and research) focused on increasing the number of abstainers. Then, someone noticed that reduced use and reduced harm occurred among non-abstainers after abstinence-based treatment (and, in fact, that this occurred more often than abstinence). A few researchers and practitioners started to see what had been "invisible" within the disease/abstinence model—namely, that many AOD-dependent people had, with or without treatment, significantly reduced their AOD use. Having noticed this, this minority began to study **how to encourage these improved outcomes, with or without abstinence**.

abstinence. Goals set by person can include abstinence. Practitioners **do advise abstinence** when that's what would be best for the person. (75, 77) It's very important to be clear on that:

Harm reduction is not opposed to abstinence!

Harm reduction can be done before, during, and after people are being helped to reduce or abstain from AOD use!

Look again at the table on page 49 comparing harm reduction to traditional AODA treatment. Traditional AODA requires abstinence for treatment; people are often discharged from treatment if they relapse. **The harm reduction model engages with people who refuse or "fail" traditional AODA treatment.** Obviously these are the people that present the greatest challenges in the context of community-based long-term care. Partnership staff have asked for clearer guidelines on how to deal with members (or families) who will not abstain from AODA use. Harm reduction is one component of their response. Again to quote an addiction physician,

> *"To refuse to work with a patient because he or she will not accept our goals for them, to not inform patients of legitimate treatment alternatives when such exist, to refuse to try legitimate alternative treatments when a particular approach has repeatedly failed because to do so would violate some 'philosophy' of treatment—all such behavior constitutes substandard medical care"(78)*

Part III--Implementation Issues

The **vast majority** of harm-reducing strategies are already standard practices in healthcare and social services. Yet the reality is that in community-based long-term care, members are free to live their lives as they choose, and "real-life" standards of risk surely differ from professional standards of risk tolerance. In consumer-focused models, professionals assume a collaborative **negotiation** mode to try to reduce risk of harm. Because of the complexities and controversies around AODA in the U.S., and the ethical questions that can arise in the more challenging situations, **non-routine harm reduction decisions will always require input from all interdisciplinary team staff as well as the member and (if applicable) involved family members**. [48] Supervisors or other skilled facilitators might help the team think through the issues clearly. [49] More specific guidelines on, e.g., setting agency limits, restricting members' liberties, and negotiating with family members with AOD problems, are provided in following chapters. This chapter, like Chapter 1, is a preliminary to such details intended to address Partnership staff's concerns with "the toughest cases"—the people with the most severe AOD dependency.

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[48] The general process is outlined in more detail in the "Guidelines on Consumer Risk-Taking" developed for Wisconsin Department of Health and Family Services by the author with the input of expert workgroups, including some Partnership staff.

[49] For example, it's important to clarify that cost-efficacy and other benefits to the agency are separate issues that cannot justify controversial harm reduction. For example, a little rum in a nutritional drink can be justified if it benefits the member through improved nutritional status, but cannot be justified by benefits to the agency (or family), e.g., by making the member more docile and easier to work with.

Negotiating harm reduction to whatever extent possible is the good work staff can always do, rather than feel there's nothing we can do.
Harm reduction is also a way out of the very unhelpful dichotomy of "enabling" versus "abandonment." **Harm reduction is improving outcomes until people are ready to reduce or quit their AOD use.** Partnership staff can work with the member "wherever they are" and can **improve outcomes** through whatever harm reduction measures the member allows, even while working with the member toward abstinence. (The latter is explained in Chapters 4 and 5.) Seeing it this way, staff can stop worrying about "enabling," and can focus on the positive things they can accomplish with these members.

As noted above, the term "harm reduction" is still inflammatory for some AODA providers. Suggestions for negotiating with traditional AODA providers are provided in Chapter 6, after an overview of AODA treatment methodologies.

Conclusion

The term "harm reduction" has two meanings: 1) as whatever community-based long-term care staff do to reduce risks or harms, regardless of the members' behaviors, and 2) as an alternative AODA treatment approach with the following characteristics:

- Strengths based
- Collaborative, flexible
- Goals are set by the person (consumer-centered) rather than by professionals
- Accepts gradual reduction, celebrates any positive steps; does not require immediate abstinence
- Success is improved outcomes, including quality of life & well-being (not merely abstinence)
- Support through numerous options (not merely requiring participation in 12-step groups)

Harm reduction is still controversial in the AODA field and often misconstrued as being laissez-faire (i.e., ignore AOD use) or anti-abstinence. Neither will be true in Partnership; harm reduction will provide Partnership staff with things they can do to minimize harm until members are ready to cut back or abstain from AOD use. The next several chapters will explain how staff can actually help members reduce or abstain from AOD use.

QUIZ FOR CHAPTER 3

1. In AODA, what does harm reduction mean?

    a. Ignore AODA
    b. Never advise abstinence
    c. Abstinence may be advised but is not required in order to obtain AODA treatment

2. When does reducing harm become controversial in community-based long-term care?

    a. When the member is unlikable.
    b. When the particular way to reduce harm seems to violate professional standards

3. Which of the following are components of the harm reduction model? (Check any that apply.)

    a. Focus on person's strengths rather than weakness
    b. Goals are set by treatment professionals
    c. Success is defined as abstinence from all mood-altering substances
    d. Small positive steps and gradual reduction in use are celebrated
    e. Success is defined by improved well-being of individual and community

4. True or False: _____ Harm reduction is anti-abstinence.

5. Which of the following are examples of harm reduction in community-based long-term care?

    a. Helping member obtain financial help so that heat and utilities are not shut off
    b. Providing safety bars in bathroom and commode in bedroom to prevent falls
    c. Contracting with alcoholic member to drink no more than 5 beers a day
    d. All of the above

6. When is it permissible to do an unorthodox thing like provide alcohol to an elderly alcoholic?

    a. When the benefits outweigh the harms and the harms are less than they would be with no interventions
    b. When everyone who cares about the person is involved in the plan
    c. When the member (or surrogate) agrees to the plan
    d. All of the above

Quiz Answers: 1 c; 2 b; 3 a, c, d, e; 4 False; 5 d; 6 d

Chapter

4

Chapter 4 – Brief Interventions

Introduction

Most people find AOD problems difficult to talk about. Part of the hesitation comes from the moral model, which makes AOD problems a topic of shame and stigma. Viewing AOD use as a chronic condition like diabetes can make it easier to talk openly about it. It also helps to remind everyone that AOD use is a normal part of human life, with benefits as well as risks. It helps even more to have a **structured** "**how to" method** to make it easier to talk with people about AOD problems. This chapter provides such a method. The method is fairly easy to learn and can be incorporated into **5 or 10 minute conversations**. Not only that—the method is actually effective in getting many people to change their AOD use or start treatment! The method is called "brief interventions." It consists of giving people feedback about their AOD use and advising them to cut back or abstain in ways that minimize resistance and maximize choice and small positive steps. Exactly how to do this has been researched quite extensively, and simple steps, guides, and even scripts have been developed (and are demonstrated later in this chapter.) The goal of brief interventions is to help people **recognize AOD problems and reduce their AOD use**. This chapter focuses on helping people recognize their AOD problems. Chapter 5 goes into more detail on how to work with people who are resistive to recognizing their AOD problems and/or not ready to reduce their use.

"Brief interventions" usually refers to interventions by health professionals who do not specialize in AODA treatment.[50] Other professionals who can provide brief interventions include emergency room staff, social workers, health educators, mental health workers, crisis hotline workers, teachers, clergy, lawyers, and employee assistance counselors (8). While brief interventions in part reflect
pressures for more inexpensive services,[51] they are being promoted because they greatly expand the opportunities for and effectiveness of **early intervention and prevention** for AOD problems. **Formal AODA treatment tends to focus only on AOD-dependent persons, while**

[50] In contrast, "brief therapies" generally refers to a limited number of sessions by AODA practitioners or psychotherapists. Both brief interventions and brief therapies can employ content from any treatment, but "brief interventions" usually now refers to the method described in this chapter. So far, brief interventions have been researched primarily in acute and primary health care settings.

[51] There is some suspicion that brief interventions are an inferior by-product of managed care. But brief interventions pre-date managed care, in the U.S. at least. They were in fact "discovered" in several 1980's British studies that showed that just 5 minutes of a doctor's advice to cut back or reduce drinking was as effective as lengthier interventions. The World Health Organization followed with several frequently-cited multinational studies of brief interventions (79)

the majority of AOD-related problems occur among non-dependent persons (8). Regular AODA screening and brief interventions could significantly reduce the harms and costs of AOD use.[52]

Most versions of brief interventions provide objective information (on the individuals' risks from AOD use) and skills development (relapse prevention, coping strategies, etc.), always with focus on positive goals and outcomes (solutions-focus) and always fostering self-determination and self-efficacy.

Interestingly, an expanding body of research shows brief interventions to be just as effective as more extensive interventions--including in-patient AODA treatment. (8, 10, 29, 41, 73)[53] Most of the brief interventions studies are with non-dependent people with hazardous or harmful AOD use.[54] Brief interventions can be effective to motivate alcohol-dependent people to enter abstinence-based AODA treatment (10). Brief interventions are also helpful with people who refuse AODA treatment, and those on AODA treatment waiting lists.

This chapter presents only the **basics** of brief interventions so that **everyone**--direct care workers, paraprofessionals, and professionals—can feel more confident talking about AOD use with members and families. Chapter 5 focuses in more detail on individuals' readiness to change. You'll learn to assess which "stage of change" a person is in, and how to adjust your interventions to where they are. You'll learn to adjust the content of your FRAMES steps to better match where the person is. For example, you'll offer different options to someone who's been sober for 7 months than you would for someone who doesn't even realize they drink too much. That level of detail might be more detailed than some paraprofessional staff need. So the goal of Chapter 4 is to provide a basic version of brief interventions to help **all staff** be able to talk about AODA whenever the opportunity arises.

Part I --Brief Interventions Using "FRAMES"

The dominant form of brief interventions being promoted in health care settings uses the harm reduction principles of a strength-based, collaborative approach that recognizes small positive steps instead of insisting on immediate abstinence.[55, 56]

Brief interventions using the FRAMES steps is easy to learn and remember. By providing

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[52] Unfortunately, proponents are having great difficulty getting healthcare providers to actually provide AODA screening and brief interventions, despite extensive outreach and proven efficacy *(ibid*, p 4).

[53] For reviews of the research, see citations 4, 5, and 6; the last document is provided in the Supplement.

[54] Some AODA experts regard brief interventions as more of an adjunct to AODA treatment than AODA treatment per se (TIP 35, 1999). However, more and more studies show that brief interventions are as effective as formal AODA treatment even for alcohol- or stimulant-dependent people (not for heroine addicts).

[55] "An overall attitude of understanding and acceptance,…active listening and helping clients explore and resolve ambivalence, [and] a focus on intermediate goals…" are the skills required to do brief interventions ((8) p. *xvii-xviii*

[56] This form of brief interventions combines motivational enhancement, cognitive behavioral (or "coping skills"), and harm reduction interventions. Motivational enhancement techniques are covered in more detail in Chapter 5, cognitive-behavioral skills in Chapter 6; harm reduction was discussed in Chapter 3.

a **step-by-step structure of what to say**, the method makes the topic less stressful and less emotional. The structure and the fact that it actually helps people (and usually avoids triggering resistance) will help you feel more confident and competent. As discussed in earlier chapters, it is never in anyone's interest to not talk about AOD problems! Early intervention and prevention is effective, cost-effective, and the right thing to do to help members and their families.

The six steps of this approach have been summarized in the acronym "FRAMES":

FRAMES
F = Feedback is given;
R = Responsibility for change lies with the person
A = Advice-giving, providing a
M = Menu of options for person to choose from
E = Express Empathy
S = Support Self-efficacy

Some of these steps are already part of your practice; most long-term care staff regularly provide feedback and advice and hopefully empathy and support to members and families. What might be different for most staff is that in FRAMES you offer **options in addition to abstinence** for the person to choose from. Also, FRAMES is structured to reduce resistance or defensiveness from the recipient. Some of this comes from the "R" step, which reminds all parties that **responsibility for change lies with the person**: You cannot change their behaviors—so you're not "set up for" frustration and feeling overly responsible. You are not going to try to control them—so they're less likely to react with resistance. And you're **giving them information and choices**—which **empowers** them. Even many people with severe AOD dependency respond well to this approach.[57] For people who have already rejected other approaches, this is always worth trying.

[57] A research summary is provided in the Supplement. As one example, 65% of alcoholics who received a brief intervention began AODA treatment, compared to 5% in the control group.

To summarize how the FRAMES steps are different from "the old way" almost all of us learned:

"Old Way"	Brief Interventions using FRAMES
I must make them stop drinking/ using.	**Only they can control their behavioral choices. My role is to offer information, support, and options.**
I have to persuade them to quit.	**My job is just to follow the FRAMES steps.**
If I can't persuade them, I've failed.	**My job is just to follow the FRAMES steps.**
I have to break through their denial, and get them to admit to a problem.	**My job is just to follow the FRAMES steps.**
I'm afraid to mention AOD use because it's too personal, too embarrassing.	**The FRAMES steps make it simply a health issue, with no judgmentalism at all.**
It's none of our business	**My job is early intervention and prevention for any chronic condition.** **My job is to provide members information and support, and to help whenever possible.**

The FRAMES Steps

Below are explanations and examples for each of the FRAMES steps. You can ask the person what they think during any of the steps. Asking their perspective at least once if not several times will reinforce that change is their responsibility and that

Feedback

Feedback is nonjudgmental, objective information connecting the person's AOD use to a health condition, lab test results, or problems (legal, relationships, housing, financial, etc.)

For **low-risk** drinker/non-user: Provide feedback that that is the category they are in and praise that, perhaps relating it to a particular health condition they have. In this way, you're providing **positive reinforcement** for their low-risk use, and a **prevention** message.
For others, here are some examples of feedback:

- Alcohol raises your blood pressure, which increases your risk for a stroke and heart disease.
- I'm very concerned about your health. Your liver is already sick; it can't handle alcohol. Alcohol is what's making you feel so lousy lately.
- One of the factors that might connect these problems is your drinking. What do you think?

Responsibility

The practitioner acknowledges that the responsibility to change lies with the person. This reduces power struggles and resistance. An important step is to engage the person in the process by asking, "What do you think? What would you prefer to do?"

That the individual is responsible for their behavior is usually implied throughout all steps. To emphasize the point, you might say something like:

- Only you can decide what you do.
- Of course, it's up to you to control your drinking, but we'd be glad to help.
- You've got some options here, some things you can choose from.

Advice

If the person has AOD risks or problems, or is AOD dependent, you will clearly advise them to quit or cut back.

- Based on these facts, I strongly advise you to stop drinking.
- To avoid harming your baby, you need to quit.
- You really need to cut back on your drinking, or quit.
- I'd like to refer you for a second opinion from a specialist.

This last one is particularly helpful with elders. Because they tend to have high levels of stigma with "alcoholism" or "drug problems," and a high respect for physicians, using medical terms like "second opinion" and "specialist" are less likely to generate resistance.

Menu of Options

Chapter 6 will provide you with more details on the options people have for formal AODA treatment and for self-help and peer support groups. Here are some examples:

- You could quit. You could go to AA, or to other self-help groups (details in Chapter 6).
- Or, you could choose to cut back.
- One thing that many people find helpful is to keep a **drinking diary**, to write down when they drink for a week or two.
- Would you **set a drinking goal**, and write it down for us to review next week?
- Would you be willing to try cutting back (or quitting) **for just a week**, to see how it goes?
- Some people switch to non-alcoholic drinks.

The next chapter will focus in more detail on people who are **not yet ready** to talk about or to change their AOD use. For now, let's keep a simple focus on how the FRAMES steps can help you talk about AOD use with people.

In healthcare settings, many people are willing to change their alcohol use. In those cases, the person is encouraged to set a goal to abstain or cut back, and **the practitioner follows up with them within a week or a few weeks**. Telephone follow up has proven effective (8, 9, 19, 41, 80, 81, 82) .

Some studies indicate that **choosing one's own drinking goal may be as or more important than the extent of problems or alcohol dependency**. This is why people are presented with "a **M**enu of options" (the "M" of the FRAMES steps.) Of course the fear is that alcoholics would choose to keep drinking. But a few studies have shown that some **70%** of severely alcohol-dependent people choose abstinence over drinking in moderation.[58] Studies show that people

[58] Perhaps some of the vehemence against controlled drinking results from this tendency for the majority of alcohol-dependent people to choose abstinence as their goal. Many traditional AODA practitioners in the U.S. are themselves in abstinence-based recovery. Abstinence is the only choice that makes sense for most of them *personally* as well as *theoretically*. Only further research will settle theoretical questions. Meanwhile we can have compassion for each other's

over time often move between the goals of moderation and abstinence. Helpers should be flexible with changing goals, and keep focusing on positive steps and reducing harm and risks. (76) While the general goals may be abstinence or moderation, people need positive reinforcement for small positive steps on the way. For these, the "sub-goals" should be set by the person and should be:

- Concrete, specific, and behavioral
- Not "feeling better" or "getting my life together," or "staying sober," but getting to work on time every day, or drinking two beers instead of five each day.
- Focus on the first small steps, not the end result
- Realistic and manageable for the person
- Recognized as hard work
- Reinforced with rewards

The practitioner helps the member set sub-goals that meet all of these criteria. Even the smallest success is acknowledged and praised. When the person does not meet a goal, this is not seen as "failure." Instead, it indicates either that the person was not really committed to the goal (perhaps the practitioner imposed it), or that barriers arose. Your response is to ask them for their perspective and make adjustments from there.

Empathy

Empathy is usually expressed in all the other steps, but you might say things like,

- You seem upset by this.
- Is this surprising to you?
- I know this has been hard to talk about, and I appreciate your talking with me.

Supporting Self-Efficacy

"Self-efficacy" is the individual's belief in themselves. It's their sense of hope that they are able to make choices in their life and more specifically to make the significant behavioral changes needed. To support self-efficacy is to promote a sense of hope, to help the person learn and practice new skills. It also means supporting the person with emotional and pragmatic supports such as housing, nutrition, and even transportation or childcare so they can go to AODA peer support groups.

- You've had sober periods before; I'm sure you'll be able to do it again.
- How can we help you follow through with this plan?
- How about if we arrange for rides to the AA meetings for the first month or so, then after that you try to arrange your own rides?
- Research shows that elders succeed just as much as younger people in cutting back or quitting alcohol.

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views and emotions about AODA, and recognize the historical, cultural, and systems influences upon us. The abstinence--non-abstinence conflict can be minimized in practice, by (1) ensuring that abstinence is always strongly advised, especially for those with problems or dependency, and (2) negotiating on shared goals of reducing human suffering and improving outcomes for as many individuals as possible--including those who (currently) reject abstinence-based treatment (recalling that many people change their goals over time).

The last example above touches upon the very common view that elders would not benefit from AODA treatment. In fact, research show that older age is not associated with poor treatment outcome, particularly in late-onset alcoholics (those who start drinking heavily late in life). Sharing this information can help make all parties more hopeful about elders' AOD problems. Elders do best if the AODA treatments are adapted for them Atkinson, 1995.

For elders, *"Improved outcome is associated with*
(1) Age-specific group treatment with supportive approach, avoiding confrontation;
(2) Focus on negative emotional states and overcoming losses;
(3) Rebuild social support network, teaching appropriate skills;
(4) Employ staff experienced and interested in working with elderly;
(5) Develop linkages with aging services, medical services, and institutional settings; and
(6) Alter pace/content for elderly" (83) (40)[59]

Example of Using FRAMES

Here is an example of how using the FRAMES acronym can make stressful situations easier for you:

Situation: *You are doing an intake assessment with Sophia, an 82-year-old woman with multiple health problems. Sophia tells you she has "always had" 2 glasses of wine with dinner every night, and 2 or 3 cocktails when she goes out with friends every few weeks. She does not drive. Sophia reads well and is cognitively fine. She answers "No" to all the CAGE questions, but you recognize that she drinks more than the recommended amounts. Since no problems have resulted from her drinking, she is in the* ***hazardous*** *drinking category.*

Formerly:

Intake staff reported thoughts and feelings about AODA issues ranging between the following two extremes:

1. *Feeling afraid to mention AOD use to person you just met; feeling unsure of what to say; afraid person will feel insulted, get angry at you and/or decide not to enroll*
2. *Feeling responsible to interdisciplinary team to find all AOD problems in advance so that team is forewarned, and to "confront" potential members with their AOD use*

Using FRAMES*: You take a deep breath, remind yourself of the FRAMES steps, and say the following:*

Transitioning: *Sophia, it's wonderful that you've been able to enjoy sensible amounts of alcohol all your life, and that you still get out to socialize with your friends. We definitely want to support you enjoying life to the fullest. I'd like to tell you a little new information about alcohol, okay?*

Sophia says, "Yes."

[59] AODA discussions (in formal AODA treatment, 12-step groups, or with long-term care staff) should be fairly straightforward for most elders. The average reading level for U.S. adults over age 70 is 5th grade. Old-old people often need content presented slowly, perhaps loudly, and sometimes repeated. (38)

***F**: There's been new research lately that as we age, our bodies can't handle alcohol as well as we used to. I can leave you a brochure that gives the details, and you can get more details from your team over the next few weeks. Experts now recommend no more than one drink a day for women over age 65. Any more than that increases the risk of falls, accidents, and health problems. Alcohol raises your blood pressure, which, as you know, puts you at risk for stroke or heart attack.*
***R**: Of course, only you get to decide how much you drink.*
***A**: Given the evidence, I would advise you to drink no more than one drink a day.*
***M**: You could quit, or you could cut back. Or, you might want to wait until you've had a chance to learn all the details from the brochure and from your team nurse. There are other options, too. Some people like to cut back gradually; others like to try cutting back or quitting for just a few weeks to see how it goes.*
Would you like to try cutting back for two weeks and see how it goes?
Sophia says, "Yes. I had no idea!"
***E**: Oh, I know, most people don't realize how alcohol can sneak up on us and cause health problems even if we only drink a little bit.*
***S**: Sounds like you've always made good choices, so I'm sure you will now. Is there anything we can do to help you in the next two weeks?*
Sophia says, "I don't think so. I'll read this information. Can I call you if I have any questions?"
You respond, "Yes, definitely. And when Stacy, your team nurse, comes to see you, she can go over the details with you and you can talk about how it's going with her. Does that sound like a good plan to you?"

Part II --Transitioning Into the FRAMES Steps

AODA is a sensitive topic for most people. If you already know a member well, you might just go right into the FRAMES steps. In most cases, however, members (and families) will feel more comfortable (and hence less resistive) if you transition into FRAMES more gradually. Any of the following conversation starters work well, depending on the context.

Ask how they are in general; expressing empathy and support, getting them to talk about their feelings and problems, then only later exploring how AOD use relates to them. This approach is especially important when you suspect the person may be using AOD to try to cope with negative feelings such as depression, loneliness, anxiety, or grief from losses. As noted in Chapter 1, it is not uncommon in long-term care for AOD problems to resolve when underlying "causes" are addressed directly.

- "How are you doing, really? You seem a bit down lately" or,
- "Seems like it's been a rough couple of weeks. How have things been for you?"
- "Has life been feeling hard for you lately?"

From here, you can move into the FRAMES steps. For example:

Feedback:"I'm concerned that you seem to be depressed lately. Many people drink alcohol when they're feeling depressed or anxious or having trouble sleeping. The truth is, alcohol actually makes all of those things worse. I'd like to explore some ways you might be able to feel better soon. (Continue through the FRAMES steps.)

Other ways to transition into FRAMES:

- ✓ Focusing on a **health concern**, introducing how AOD use affects it
- ✓ Focusing on **another concern** (such as relationship problems, threat of eviction, running out of money) and introducing how AOD use affects it
- ✓ If you just completed an **AODA screen** with the person, it will often be natural to stay focused on the screen itself. Here the objectivity of the screen can help to reduce the member's fear of being judged. You and the member together focus on the screen rather than on their behavior (which might generate defensiveness).
- ✓ For younger adults, another way to provide feedback is to let them know how much they drink compared to other U.S. adults of same gender. You can show them a chart of "**consumption norms**" (average drinking amounts). People are often surprised to realize that they drink more than, say, 98% of other adults. Realizing this can sometimes motivate people to cut back.

With Elders

With elders, it is usually best to frame AOD use in context of a **health problem** rather than focus directly on quantity (consumption norms). Many elders may only be drinking the same amount they've always drunk without any problem; they may have no awareness at all that their body can't handle it as well anymore. In these instances, their reaction might be shock and indignation that you would imply that they are an alcoholic or drug abuser. **Avoid terms like "drinking problem," "alcoholism," "drug abuse," etc. with elders.** Instead, tie their AODA use to its effects, especially health effects.

Elders tend to have a lot of shame and stigma around AOD problems. They don't want anyone to know, especially family (particularly grandchildren). (38) **Frame your conversation around a health concern.** Stay engaged with them in a joint problem solving about the health issue, to prevent them from getting defensive that you're accusing them of drinking too much. For the same reason, focus on the **reduced tolerance from aging**. There's a good chance they **are not aware** that the small and "normal" (as in usual for them and socially/morally acceptable) amount they're drinking could cause problems. Provide them this information in a non-judgmental way, again with a focus on their specific health problem.

> ***Examples***
> *Let's go back to Sophia, the 82-year-old woman discussed a few pages ago. Sophia tells you she has "always had" 2 glasses of wine with dinner every night, and 2 or 3 cocktails when she goes out with friends every few weeks. She does not drive. Sophia reads well and is cognitively fine. She answers "No" to all the CAGE questions, but you recognize that she drinks more than the recommended amounts. Since no problems have resulted from her drinking, she is in the hazardous drinking category.*
>
> ***Transitioning:*** *Sophia, it's wonderful that you've been able to enjoy sensible amounts of alcohol all your life, and that you still get out to socialize with your friends. We definitely*

want to support you enjoying life to the fullest. I'd like to tell you a little new information about alcohol, okay?
Feedback: *There's been new research lately that as we age, our bodies can't handle alcohol as well as we used to. I can leave you a brochure that gives the details, and you can get more details from your team over the next few weeks. Experts now recommend no more than one drink a day for women over age 65. Any more than that increases the risk of falls, accidents, and health problems. Alcohol raises your blood pressure, which, as you know, puts you at risk for stroke or heart attack.*

Example:
"I'm noticing that your [blood sugar /clotting time/ blood pressure] has been a bit out of control lately. I wonder what's causing this. You know, sometimes even just a little alcohol or beer can impact this. I'd like to try to map this out to see if this might be affecting your health lately."

Part III – Self-Medicating with AOD

It is very common in long-term care to encounter people who are using alcohol or drugs to medicate particular problems. There is no crisp line separating such "self-medication" from AOD misuse or abuse. It is not a matter of professional diagnosis as much as the member's own explanation of why they use—what they are trying to obtain from their use. Self-medication can be with alcohol, **prescription meds**, or illegal drugs. The person may be addicted to the AOD, but more often they may be using it to "solve" a particular problem such as pain, insomnia, anxiety. Their self-medication may be based on **misinformation**: For example, many people think alcohol helps them sleep, but it actually disturbs sleep; others use AOD to drown out their feelings, but alcohol and other drugs cause depression.[60] Their AOD use (including misuse of prescription meds) may create risks or problems.

Sometimes, of course, members will claim medicinal reasons for their AOD misuse that may seem exaggerated. This may be a form of self-delusion or a form of resistance. The good news is that it doesn't really matter; the method explained below will work regardless of the member's level of honesty. Do not waste your efforts trying to argue over it; remember, "Roll with Resistance!"

Adapting FRAMES for "Self-Medication"

Someone who is using AOD to self-medicate may have a primary interest in being able to solve that problem. Indeed, they might be quite desperate, for instance, to avoid their chronic pain or anxiety. If you focus only on their AOD problem, you are likely to trigger fear and/or resistance from them. From the very beginning, you want to convey that you understand their underlying problem, respect their attempts to solve it, and are committed to helping them solve it. The point is that you're not just reacting to their problem AOD use; you're recognizing the underlying problem and allying with them to explore more helpful ways to treat it. To do this, you simply "stretch" the FRAMES steps to include both the AOD use and the underlying problem, as follows:

1. Provide **Feedback** about the real effects of their use and any risks or problems it creates.
2. Acknowledge that they have **Responsibility** to choose their AOD use and how to manage their underlying problem. Say that you will provide or help them find healthcare providers who will **share the responsibility** of addressing their underlying problems.
3. Provide **Advice** not only regarding their AOD use, but also regarding their underlying problem.
4. Present a **Menu of Options** for them not only regarding their AOD use, but also regarding various ways to address the underlying problem they're trying to solve with AOD. Make a commitment to help members obtain high quality healthcare to address the underlying problem.

[60] More details are provided in the Supplement.

5. Express **Empathy** not only regarding their AOD use, but also regarding their underlying problem.
6. **Support self-efficacy** with a "can-do" attitude and by offering **pragmatic supports** not only regarding their AOD use, but also regarding their underlying problem.

Chronic pain is a special case of an underlying problem that people often try to self-medicate with AOD, including prescription med misuse. Chapter 6 will discuss in more detail some methods found to help improve pain control and reduce drug-seeking/pain control- seeking behaviors.
In fact, Chapter 6 will provide an overview of AODA treatments that, borrowing from psychotherapy, address numerous underlying problems and help people replace AOD use with other ways to cope.

Medicinal Marijuana
In the case of marijuana, some of your members may tell you that they are obtaining medicinal benefits from the drug. Of course the illegal status of marijuana in the U.S. creates risks to its use.[61] The apparent benefits of medicinal marijuana outweigh its known harms enough for some countries to legalize its medicinal use: Cannibis is helpful with "glaucoma, asthma, epileptic seizures, chemotherapy-induced nausea, neuropathic pain, spasticity with MS or spinal cord injuries, and [as an appetite stimulant in] cancer- and AIDS-related wasting. This evidence of therapeutic potential warrants further clinical trials." (84) Other studies show that marijuana (or its active ingredient, THC) may have anti-seizure, antidepressant, and anti-anxiety properties as well. However, marijuana is classified as a Schedule I narcotic, a status that currently disallows any further studies in the U.S.

Acute effects of marijuana include euphoria, paranoia, or anxiety; increased pulse and blood pressure; bronchodilation; impaired learning, perception, short-term memory, reaction time, and motor coordination (contributing to auto accidents) (85)

Anyone with family history of schizophrenia should avoid marijuana, as it can trigger schizophrenia in susceptible persons. Long-term effects of marijuana include respiratory problems (chronic emphysema and bronchitis, cancer) similar but at lower rates than with tobacco (probably due to lower volume smoked),[62] and (reversible) reduced sperm counts. Marijuana crosses the placenta but no birth defects have been documented (84). Heavy marijuana use may cause "amotivational syndrome."

Part IV--Implementation Issues

[61] It is not clear that members' marijuana use creates any risk to providers. As a provider of in-home health and social services, your duty to uphold confidentiality overrides everything except mandatory reporting of suspected child or elder abuse. Risks to members caused by families' drug use are discussed in Chapter 9.
[62] "Although acute low doses of marijuana may lead to bronchodilation, higher doses or chronic use may lead to the constriction of bronchial airways" (84, p. 185)

The Wisconsin Partnership Program uses an interdisciplinary model based on Dr. Barbara Bowers' research that that is the most effective way to facilitate member-centered care.[63] Partnership staff raised questions about role responsibilities regarding members' AOD problems. This chapter presented a **basic** form of brief interventions with the goal of making it accessible to the maximum number of staff--paraprofessional as well as professional.[64] The topic of AODA can come up at any time. At least some paraprofessionals want to know how they should respond. The basic FRAMES steps can help them feel more comfortable and confident when the topic comes up in their interactions with members and families. Of course they will refer the member to professionals for more information and follow up, but FRAMES provides at least some basic concepts to make AODA a less intimidating issue. Paraprofessionals can help reinforce the basic principles of brief interventions in their daily conversations with members.

Among professionals, it is suggested that **all** who interact with members or families will provide at least the basic brief interventions whenever the opportunity arises. Physical therapists and PT aides; occupational therapists and OT aides; recreational therapists; day clinic staff, etc. all spend time talking with members. In these conversations, the topic of AOD problems will arise (or can be discerned by noticing "red flags" discussed in Chapter 2). Since most AOD problems are overlooked, the more staff involved in these brief interventions the better. There is no need to restrict brief interventions to only particular professionals.

Conclusion

This chapter presented an easy-to-learn step-by-step method to make it easier to bring up the topic of about AOD problems with people. The steps can be remembered with the FRAMES acronym.
This basic form of brief interventions was developed for non-AODA providers. It can be done by almost anyone who converses with Partnership members or families. This can become a "minimum standard" for professional staff (if not for paraprofessionals as well). In this way, no opportunities will be missed for early intervention and prevention around AOD problems.

[63] See www.dhfs.state.wi.us/Wipartnership/QualityResearch.htm for Bowers' Partnership studies and reports.
[64] More advanced brief interventions will incorporate the stages of change as explained in Chapter 5.

QUIZ FOR CHAPTER 4

1. _____ True or False? The FRAMES acronym stands for the following:

   F = Feedback is given;
   R = Responsibility for change lies with the person
   A = Advice-giving, providing a
   M = Menu of options for person to choose from
   E = Express Empathy
   S = Support Self-efficacy and provide pragmatic Supports

2. How do brief interventions using FRAMES differ from what has traditionally been done?

   a. People are given options to choose from, including choosing their own goals of cutting back or abstaining
   b. People are not confronted with the labels "alcoholic" or "addict"
   c. Both a and b

3. Why are brief interventions being promoted?

   a. To allow for earlier intervention and prevention for AOD
   b. Because formal AODA treatment is restricted to AOD-dependent people
   c. Because the majority of alcohol-related problems occur in non-dependent people with hazardous or harmful drinking
   d. Because brief interventions can help people who refuse formal AODA treatment
   e. All of the above

4. Which of these statements reflect a healthcare provider doing brief interventions?

   a. We will not continue to provide your health care if you don't stop drinking.
   b. So you've set a goal to cut back to 5 beers a day. How about if we call you in a week to see how you're doing with your plan?

5. What are some options you might offer to someone with at-risk/hazardous drinking?

   a. Keep a drinking diary for 2 weeks
   b. Set a drinking goal for reduced intake
   c. Stop drinking
   d. All of the above

6. What does the "Responsibility" step mean in FRAMES?

    a. The person is to blame for their bad behaviors
    b. No one else can force them to quit or cut back their AOD use
    c. It's just a question of willpower

7. How many alcohol-dependent people, if given the choice, choose abstinence over cutting back?

    a. 10%
    b. 40%
    c. 70%

8. Which of the following are good goals for someone who is AOD-dependent?

    a. I have to get my act together
    b. I will smoke pot only once a day and drink only 4 beers a day

9. How can AODA treatment be adapted to work better for elders?

    a. Peer groups of elders
    b. Supportive approach, avoiding confrontation
    c. Slower pace, briefer content, repeating things as needed
    d. Address loneliness, anxiety, depression, losses, social roles
    e. All of the above

10. What is the best way to talk about AOD problems with elders?

    a. Always tying them to health concerns
    b. Stressing that aging reduces body's tolerance for AOD
    c. Avoiding stigma or guilt of labels like "alcoholism" or "addicted"
    d. All of the above

Quiz Answers:
1 True, 2 c, 3 e, 4 b, 5 d, 6 b, 7 c, 8 b, 9 e, 10 d

CHAPTER

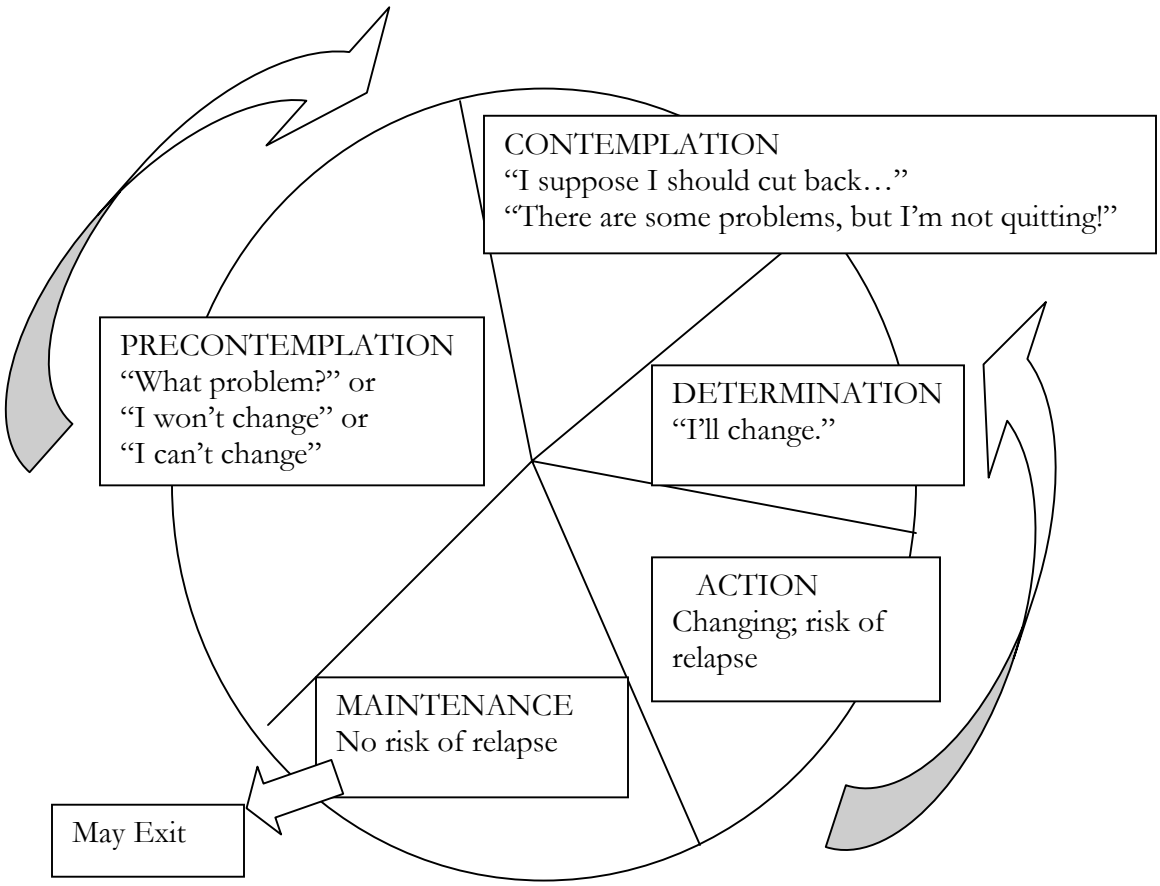
5

Chapter 5 – The Stages Of Change And Motivational Enhancement Techniques

Introduction

Chapter 4 provided a straightforward way to talk about AOD use with people. Of course, if everyone reacted, "Oh, thank you, I shall quit immediately!" AOD problems would hardly exist. In fact, as you well know, many people do not react that way. This chapter provides some specific ways to work more effectively with people at various points in the process of changing their AOD use behaviors—including people who are not ready to change.

The Stages of Change Model



Part I – The Stages of Change

The diagram on the previous page represents DiClemente and Prochaska's "transtheoretical stages of change model" of the phases that people go through to make significant behavioral changes. (86, 87) This stages of change model has been widely used in social work, psychology, and the AODA field. (88, 89, 90, 91, 92, 93, 94) It is most helpful for practitioners working with people who are not yet ready to change their high-risk behaviors.

The stages of change are not linear. It is normal to move from one to another, forward and back. People move backwards in the stages when they've encountered difficulties or when their resistance has been triggered. Getting ahead of individuals—e.g., expecting abstinence immediately—causes resistance. "Stage-appropriate interventions" are far more effective in promoting long-term behavioral changes and are now recommended in AODA guidelines. (8, 87, {SAMHSA/CSAT, 1999 #272)}"

Your role is to **recognize** which stage of change the individual is in, and provide conversations and supports to **help them move to the next stage of change. That's all!** You are only responsible for assessing the stage of change they are in and saying specific things appropriate to that stage (plus negotiating harm reduction as explained in Chapter 3). The stages of change are not mysterious. You'll be able to tell which stage of change a person is in based on the things they say and do, as indicated in the following list of the stages.

The Stages of Change

- **Pre-Contemplation:** Individual does not recognize problems and is not considering change. This may be due to:
  - Lack of information ("I didn't realize this was too much.")
  - Contentment with the present ("I'm happy this way; I don't want to change.")
  - Hopelessness, fear of failure ("It's too late." "I can't do it." "I'll just fail again.")

- **Contemplation:** The individual acknowledges concerns but is uncertain about changing.
  - Given opportunities to "think out loud," to talk with someone, the person in this stage will eventually (perhaps with some cueing) express **ambivalence—**some of the "downside" of their use

- **Determination or Preparation:** The individual is committed to and planning to make a change in the near future but is still considering what to do.

- **Action:** The individual is actively taking steps to change but has not yet reached a stable state. Example: Someone regularly attending AA meetings for the past year.

- **Maintenance:** The individual has achieved initial goals such as abstinence and is now working to maintain gains.

- **Recurrence:** The individual has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.

The stages of change are not just for theory. They are the basis for helping you work more effectively with people at **any** stage of change. Traditional AODA treatment starts when the individual is ready to change or is forced to attend treatment. Long-term care staff need to know how to work with people who are not ready to change, and/or who refuse AODA treatment. In other words, it is people in the Precontemplation and Contemplation stages who present the greatest challenges in community-based long-term care.

Just as Chapter 2 showed that people move around in the various drinking categories (low risk, hazardous, harmful), so people move around in the stages of change. A person might have spent years in the Maintenance stage (attending AA meetings and staying sober) and then have a "Recurrence" (a relapse). The person might relapse just once, and quickly re-enter the Action stage to regain sobriety. Or, she might relapse longer term and go back to Precontemplation, feeling afraid to even consider quitting again because she "failed." No matter which stage of

change someone is in, there is always something helpful you can do. You can always provide them support appropriate for their stage of change. Also notice that even people in Action and Maintenance stages still need on-going support and occasional advice and help.

Assessing Stages of Change

As noted above, it's fairly easy to tell from what people say and do which stage of change they're in.

There is a short-cut question that is often used in brief interventions (beyond the basics explained in Chapter 4), which is, "On a scale of 1 to 10, how ready do you feel to change your AOD use?" This "readiness ruler" helps you and the member focus on small steps so you can both perceive progress in the direction of change. Here's an example:

> *Client: Well, now I feel like an "8" but I know it's temporary. When I go back home, I'll probably get back to a "2" right away.*
> *Therapist: "That's good because slow change is more important than fast change. You really can't count on fast change to last. So if you did slip back to a "2," what would it take to move you to a "3"? At this point the therapist is ready to define some kind of action and seek commitment to change. The response is also intended to encourage the client by identifying small, feasible steps. (8, pg. 96)*

While this example is from brief therapy done by a therapist—which you are not expected to do—it is a good illustration of not trying to rush change, and focusing on small realistic steps. The next section explains more about the most effective interventions depending on which stage of change the individual is in.

Part II —- Motivational Enhancement Techniques Interventions For Each Stage Of Change

Motivational enhancement techniques[65] are interventions adapted to the person's stage of change, with the goal of helping the person move to the next stage of change. Ideally, all your members (or their family members) will decide to enter formal AODA treatment to receive the supports and skills training they need. But **for members who refuse AODA treatment**, **these interventions are (along with harm reduction) the most effective and cost-effective responses you can make.**

In fact, progress through the stages of change can be used as a measure of success. (For example, 80% of dually-diagnosed persons receiving mental health services moved from Precontemplation to Contemplation or Action stages regarding their AOD use within 6 months. {Minkoff, 2001 #635}

[65] The proper term is "motivational enhancement therapies." Since Partnership staff are not expected to provide psychotherapies or formal AODA treatment, the term "technique" is used here.

Progress through the stages of change is even being used to measure success for, e.g., diabetes education. This is good news because it creates smaller steps of progress—more opportunities to perceive "success." The next section explains how you can promote such successes.

Your Role:

1. Assess which stage person is in at the moment.
2. Adjust your interventions according to the stage the person is in.
3. Your goal is to help person proceed to the next stage. (That's all! Your immediate goal is not abstinence!)

Learning to adjust what you say to the member's stage of change will take some practice. It's well worth the effort because

(a) It provides clearer and more feasible job expectations for you and your agency [66]
(b) It is less likely to generate resistance from members (or families)
(c) It is more effective in promoting behavioral changes and improved outcomes [67]

Tips for Doing MET

The following are **tips** on the method of doing MET [68]

1. Ask open-ended questions (those that cannot be answered with "yes" or "no")
2. Listen reflectively
3. Summarize
4. Affirm the member's strengths, motivation, intentions, and progress
5. Elicit self-motivational statements, i.e., encourage the person to voice personal concerns and intentions, rather than try to persuade the client that change is necessary

4 Principles of MET

The four **principles** of Motivational Enhancement are these:

1) Express empathy

This can be difficult with AODA. Perceiving AODA as a chronic condition like diabetes or as a coping mechanism will help.

2) Develop discrepancies (or, "amplify ambivalence")

Help the individual recognize a conflict (discrepancy) between their AOD use and their other goals or desires. Ask them about all the **pros** –all the good aspects--of their AOD use before asking about **cons**—the downside of their use.

3) Roll with resistance

Resistance is not a character trait; it is self-protective behavior. Resistance is a **cue** to you that the member feels threatened by something. You want to look for and listen for signs of resistance, because it can help you avoid wasting time and energy. Forms of resistance include hostility, discounting your feedback, passivity, acquiescence (just saying "Yes" to please you or to end the conversation), not following through (although this could be

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[66] Details on this are provided at the end of this chapter.

[67] There is extensive research supporting the efficacy of motivational enhancement. {Hester, 2003 #307;Miller, 2003 #611;Miller, 2002 #244;Miller, 2002 #609;Velasquez, 2001 #11;Carey, 2001 #240;Barrowclough, 2001 #337;Boren, 2000 #10;Foote, 1999 #19;SAMHSA/CSAT, 1999 #272;Joe, 1998 #150;Peteet, 1998 #188}

[68] These are adapted from SAMHSA TIP #35

due to barriers encountered; you have to ask). People usually give nonverbal cues of resistance—poor eye contact, frowning, turning away, closed body (arms and legs crossed), shutting down, or getting agitated.

4) Support self-efficacy

Have a "can-do!" attitude instead of a "shouldn't." Celebrate any positive change.

MET Interventions for Each Stage of Change of Change

Below is a summary of interventions for each stage of change. Chapter 6 provides more details on specific AODA treatments, such as helping the person develop new coping skills. For now you can focus on noticing how your interventions match where the person is.

Pre-Contemplation: Individual does not recognize problem, due to:

- Contentment with the present,
- Lack of information, and/or
- Low self-efficacy (self-confidence), i.e., hopelessness, fear of failure

✓ Establish rapport, ask permission to discuss, build trust
✓ Ask person about **pros** of AOD use; then explore cons of AOD use
✓ Examine discrepancies between the individual's and others' perceptions of the problem behavior; explore the meaning of AOD-related problems or the results of previous treatments
✓ Express concern and keep the door open

Contemplation: The individual acknowledges concerns but is uncertain about changing.

✓ Normalize ambivalence
✓ Eliciting and weighing **pros and cons** of substance use and of change
✓ Through selective reflection, help them "tip the scale" toward changing
✓ Emphasizing the individual's free choice, responsibility
- Elicit self-motivational statements of intent and commitment
- Reflect back and summarize self-motivational statements

✓ Ask about the individual's perceived self-efficacy and expectations about treatment

Determination/Preparation: The individual is committed to and planning to make a change in the near future but is still considering what to do.

✓ Offer a menu of options for change or treatment
✓ Negotiate a change—or treatment—plan and behavior contract
✓ Address barriers to change
✓ Help the individual enlist social support
✓ Explore and build on earlier successes
✓ Offer pragmatic supports with finances, childcare, work, transportation, etc.

Action: The individual is actively taking steps to change but has not yet reached a stable state.

- ✓ Engage the individual in treatment and reinforce the importance of remaining in recovery
- ✓ Support a realistic view of change through small steps
- ✓ Acknowledge difficulties for the individual in early stages of change
- ✓ Help the individual identify high-risk situations and develop appropriate coping strategies to overcome these
- ✓ Assist the individual in finding better and better reasons to change
- ✓ Help the individual assess whether she has strong family and social support

Maintenance: The individual has achieved initial goals such as abstinence and is now working to maintain gains.

- ✓ Support lifestyle changes
- ✓ Affirm the individual's self-efficacy and choices
- ✓ Help the individual explore AOD-free sources of pleasure
- ✓ Help the individual practice and use new coping strategies to avoid a return to use
- ✓ Maintain supportive contact
- ✓ Develop plan for responding to relapses
- ✓ Review long-term goals with the individual

Recurrence: The individual has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.

- ✓ Help the individual re-enter the change cycle and commend any willingness to reconsider positive change
- ✓ Explore the meaning and reality of the recurrence as a learning opportunity
- ✓ Assist the individual in finding alternative coping strategies
- ✓ Maintain supportive contact

Sample Questions To Elicit Self-Motivational Statements (*adapted from TIP # 35)*

- What difficulties have you had in relation to your drug use?
- In what ways do you think you or other people have been harmed by your drinking?
- How has your AOD use stopped you from doing what you want to do?
- What worries you about your drug use? What can you imagine happening to you?
- What do you think will happen if you don't make a change?
- What makes you think that you may need to make a change?
- If things could be exactly as you would like, what would be different?
- What things make you think that you should keep on drinking the way you have been? And what about the other side? What makes you think it's time for a change?
- What makes you think that if you decide to make a change, you could do it?
- What do you think would work for you, if you needed to change?
- How is your drug use affecting your health? How is your drinking affecting your family?
- Help me understand. You've been saying you see no need to change, and you also are concerned about losing your family. I don't see how this fits together. It must be confusing for you.

- On the one hand, you're afraid about your health, but on the other hand you keep mixing alcohol and drugs with your meds. Sounds like you've got a bit of a dilemma here.
- Why do you think your probation officer thinks you have a problem?

Examples of Doing MET with People in Precontemplation or Contemplation

FRANK (72-year old): I hate that doctor. He's an arrogant SOB calling me a drunk. I've never had a drinking problem in my life.
You're tempted to say: *Frank, you're an alcoholic! (Fantasy Frank: Oh yes, you're right, I forgot.)*
Instead: You know elders like Frank have a great deal of stigma (shame and resistance) around the "alcoholic" label, so you don't use it—even though Frank has probably actually been alcohol dependent for years. You know that last month Frank had been in Contemplation stage, discussing his problem drinking with you. Now, having been triggered into resistance by the MD mentioning his alcoholism diagnosis, Frank has reverted back to the **Precontemplation** stage. So your goal is to help him get from that back to Contemplation.
YOU: Yes, and last month we talked about how alcohol can sneak up on you when you get older, and cause problems even if you don't drink a whole lot. *(Frank is likely to hear the last phrase as "even if you're not an alcoholic," and perceive you as an ally.)*
FRANK: Damn right. Oh, I know I can't handle it as much as I used to, from getting old, but I'm no drunk.
He's still resistant about the alcoholic label. But you catch hold of that little bit of ambivalence and reflect it:
YOU: Yeah, last time we talked about how as you age your body can't handle alcohol much. Just a few beers a day is really messing up your liver and your diabetes now…
FRANK: Yeah. I know I'm getting sicker and feeling lousy lately… But I ain't quitting, it's all I got left.
You're tempted to say: *You have to quit, it's killing you. Frank's likely response would be resistance.*
Instead: You recognize that he's back into **Contemplation**, so celebrate that progress! You note him saying "It's all I got left" as indication to work on Frank's pastimes and social life. For now, reducing his drinking is top priority for his health problems.
YOU: Yes, nobody can make you quit. So have you thought of anything since last time, about what you can do to feel better day-to-day?

Example of Contemplation

YOU (after doing FRAMES): Tim, have you ever tried to quit before?
TIM: Well, no, but I know I should.
You're tempted to say: *"Good, then, you'll quit."* You know "Should" isn't going to work.
Instead, you resist the temptation to rush Tim. He's only in the **Contemplation** stage, and he is easily triggered into resistance. If you push him too fast, he'll make another

promise to quit (just to end this uncomfortable conversation) that he won't follow through on. So you provide the interventions appropriate for someone in Contemplation:
YOU: Why do you think you should quit or cut back?
TIM: Well, they say it's messing up my health.
You're tempted to say: *"Yes, it is, you should quit."*
Instead, you notice how vague and passive Tim's being. This is a mild form of resistance, so you know not to rush him. You provide the interventions appropriate for the Contemplation stage:
YOU: Yes, we did talk about the health effects earlier. So tell me about why you wouldn't want to quit. Tell me about all the good stuff about drinking and smoking.
TIM: Well, it's fun. It's what we do, me and my friends, we party.
YOU: So it's a big part of your fun with your friends; what else?
TIM: Well, it feels good, it feels great being high.
YOU: Anything else?
TIM: Hey, that's enough, isn't it? It feels good, I do it.
YOU: Well, that's understandable. So are there any aspects that don't work so well for you?
TIM: Yeah… I'm feeling pretty lousy lately. I guess I'm getting too old for these hangovers or something.
YOU: *Knowing that long-term health effects do not motivate Tim very much, you help him focus on more current effects of his use. Your goal is to help him talk himself toward wanting to change.*

Part III – Implementation Issues

Chapter 4 presented a basic version of the FRAMES steps to help staff feel more confident about talking about AODA with members and families. This chapter went deeper to explore the stages of change and interventions appropriate for each of them. Motivational enhancement techniques (MET) will make staff's jobs easier by providing smaller and more feasible goals for "success"; they are also shown to be effective in promoting behavioral changes.

In practice, MET and brief interventions are integrated, such that the feedback and advice matches the member's stage of change. Many members will appreciate the feedback and be immediately ready to reduce their AOD use. In these instances, brief interventions will move fairly quickly into setting drinking/use goals and following up on them. Other members, however, may have already received brief interventions and are not ready to change their use; in these situations the focus will be more on MET. Still, the advice to quit and/or to begin AODA treatment is always offered as an option to those with serious problems or dependency. Such stage-appropriate interventions can be done in only 5- to 15-minute conversations.

Staff will need agency support to implement MET. MET is more complex to learn than brief interventions, and staff will need opportunities to practice it. All staff and managers must agree to recognize and celebrate smaller steps of successes, such as helping a member move from Precontemplation to Contemplation.

One of the key goals of this manual has been to propose clearer and more reasonable expectations for Partnership staff and agencies regarding members with AOD problems. While Chapters 6 – 9 present additional information, enough has been learned at this point to stop and examine how the interventions recommended thus far will meet that goal.

Problem as stated by Partnership staff
We feel like nothing we do is ever enough. We're afraid we'll be blamed if we can't stop AODA, or if something bad happens because of it. Everyone just tells us to just try harder.

Solutions

- The interventions explained in this training can become the **minimum standards and the maximum responsibilities** for WPP staff. Expectations will be more realistic, feasible, and clear for all.
- **Minimum standards** can be used to tell staff what they must be sure to do (for example, to advise people with AOD problems to quit or cut back to recommend AODA treatment, and to treat AODA like other chronic conditions).
- The standards have been designed to capture the **maximum responsibilities** of staff as well. In other words, no matter what happens, if staff followed the standards, they have fulfilled their job responsibilities. Their practice was not negligent and they are not liable for harm resulting from the member's AODA.
- The proposed standards are presented in this training. Each agency can adapt these standards to implement an agency-wide approach to AODA. The standards and training materials can be incorporated as performance standards and policies and procedures. They can also work in quality improvement reviews, to guide retrospective analyses of situations.

Here, for example, is part of a "Minimum Standards for Addressing AODA" that Partnership agencies could adopt. (Some steps reflecting guidelines in Chapters 6-9 are added later.) These performance expectations clearly state the responsibilities of staff and agencies. Since staff and agencies cannot actually control members' behavior, responsibilities are limited to the below.

1. Provide AODA screening if required in job description (e.g., intake staff, team RN) and provide follow up as indicated
2. Respond to any indications of possible AOD problems among members or their families
   Paraprofessionals: Report to interdisciplinary team any indications of possible AOD problems among members or their families
3. Employ agency-wide model of AODA as a chronic health condition
4. Negotiate harm reduction, adapted to suit the individual and circumstances
5. Provide brief interventions using FRAMES (includes recommending abstinence and AODA treatment to persons with serious problems or dependency)
6. Recognize which stage of change person is in and provide stage-appropriate interventions
7. Address underlying issues—e.g., pain, insomnia, hopelessness, depression, loneliness, grief, loss of purpose in life—with which person may be using AOD to cope

Agencies might revise these to fit their usual policies and procedures, but the idea is to systematize clearer and more reasonable expectations for staff working with members with AOD problems.

In practice, in the most difficult situations it might be best to have at least **two** different people do brief interventions, harm reduction, and MET. Be mindful of power dynamics and personality conflicts. Do not hesitate to reassign members, especially if team staff are feeling "burned out."

Since at this point it seems possible that some of the success of brief interventions may derive from the authority of healthcare providers, nurse practitioners and physicians should be particularly encouraged to routinely provide brief interventions. Longer-range strategies might be to distribute brief interventions materials to members' physicians and request that they incorporate them.

QUIZ FOR CHAPTER 5 –

For every case below, you have just done brief interventions using FRAMES with the consumer, and this is what they say next.

83-year-old **Gerta** says, "No, now I've tried before, and I've always failed; I'm not trying again. It's too late. I'm too old, too tired. I don't want to fail again."

1. What stage of change is Gerta in?
    a. Maintenance
    b. Precontemplation
    c. Action
2. From what she just said, which of the following seems to be the primary reason Gerta is in this stage?
    a. Contentment with the present
    b. Lack of information
    c. Lack of self-confidence in ability to change, hopelessness, fear of failure

Doug (age 59) says, "There's nothing wrong with partying. I'm not addicted to anything, I just like getting high, and a little coke when we can get it. We have a good time every month; it's fun.

3. What stage of change is Doug in?
    a. Contemplation
    b. Precontemplation
    c. Action
4. From what he just said, which of the following seems to be the primary reason Doug is in this stage?
    a. Contentment with the present
    b. Lack of information
    c. Lack of self-confidence in ability to change, hopelessness, fear of failure

Mary says, "Look, I just won't drive again after drinking. I didn't mean to; it just happened."

5. What stage of change is Mary in?
    a. Contemplation
    b. Precontemplation
    c. Action

Ayesha says, "I'm doing alright, I'm still going to NA (Narcotics Anonymous) meetings, but it's hard, I still get cravings to use sometimes."

6. What stage of change is Ayesha in?
    a. Contemplation
    b. Precontemplation
    c. Action

Herb is a 77 year old Norwegian-American living alone on his farmstead. Herb gets around with a walker, and can still drive into town. He has a weak heart (congestive heart failure, coronary artery disease, history of heart attacks and of cardiac by-pass in 1994), high blood pressure, diabetes with foot ulcers, psoriasis, COPD, and mild liver disease and mild kidney disease. You do FRAMES, and Herb says, "I don't drink any more than any other farmers out here. Besides, they say a little booze is good for your heart, so you don't know what you're talking about."

7. What stage of change is Herb in?
    a. Contemplation
    b. Precontemplation
    c. Action

8. From what he just said, which of the following do you think are the primary reasons Herb is in this stage?
    a. Contentment with the present
    b. Lack of information
    c. Lack of self-confidence in ability to change
    d. a and b

9. Why do you think Herb said you don't know what you're talking about?
    a. He's being verbally abusive
    b. Questioning my information is a form of resistance; Herb's resistance got triggered just by the FRAMES steps, which indicates a high level of fear and defensiveness about his drinking
    c. He's being noncompliant, as usual

10. What would you say next to Herb?
    a. Yes, you've got a good community of friends here, Herb, all your old farming buddies. Do you still get to see them often?
    b. I happen to have a masters' degree, so I do know what I'm talking about.
    c. Herb, I came here to help you. You must listen to me, you have got to stop drinking immediately.

Quiz Answers:
1 b, 2 c, 3 a, 4 a (or b), 5 a, 6 c, 7 b, 8 d, 9 b, 10 a

CHAPTER

6

Chapter 6–AODA Treatment Options

Introduction

You have learned in previous chapters that you'll **always inform** people of the risks or harms of their AOD use, **advise** them to cut back or abstain, **and offer options** from which they can choose. You've learned that it's more effective to "meet people where they are" in the stage of change, adjust what you say to that, and see small steps of progress toward change.

Now you can learn more details about the various options for AODA treatment. The options are of two general categories—those provided in formal AODA treatment programs, and those that people can do on their own ("self-help" or "informal") or with your assistance. The categories overlap, because whatever is helpful in one setting will cross over for use in the other. So, for example, most formal AODA treatment now includes homework assignments in self-help workbooks. Many self-help workbooks incorporate strategies originally developed in professional treatment settings. Also, the move toward briefer interventions has generated simplified versions of most of the methods of formal treatment. These are called "brief therapies." Some brief therapies have been modified into self-help workbooks that anyone can use. Other brief therapies require professional therapists. The explosion of self-help books and peer support programs makes the line between "professional therapy" and "self-help" extremely vague. Most long-term care case managers and nurses do not have the training or licensure to provide therapy or AODA treatment. Yet as part of harm reduction, long-term care staff can provide brief interventions and help members with self-help strategies as best they can until the member accepts more formal treatment.

Since members who refuse formal AODA treatment present the greatest challenges for long-term care staff, the self-help and brief interventions will be most helpful for Partnership staff. Self-help and brief interventions are also useful for people on waiting lists for formal AODA treatment.

You'll also want to understand formal AODA treatment so you can help members make choices about treatment, and so that you can more knowledgeably interact with AODA providers. Since most self-help and brief therapies are derived from formal AODA treatment methods, those are presented first, in Part I. The AODA field has its own vocabulary, which is introduced here to help those staff who will be speaking with AODA providers. (Despite the technical terms, many of the interventions are fairly common sense strategies.)

Part I – Methods of Formal AODA Treatment

First, some technical terms: "Psychosocial treatment," "cognitive behavioral therapies (CBT)" and "community Reinforcement Treatment (CRT)" are essentially synonymous umbrella terms for methods that use behavioral principles to help people develop new skills and resources to live without AOD.[69] They include all of the below.

Peer Support Groups
12- Step Programs: Alcoholics Anonymous (AA), Narcotics Anonymous (NA)
(Al-Anon and Alateen for significant others and children of alcoholics.)

Cognitive-Behavioral Therapies
A combination of "cognitive" and "behavioral" therapies
Cognitive Therapy = Learning to identify and modify unhelpful thought patterns[70]
Effective even with persons with lower cognitive functioning (51)

Behavioral therapies, or "Behavioral self-control strategies"

- Goal setting: Individual sets specific goals (on own or with suggestions)[71], writes them down
    - **"Solutions-focused**" model in which goals are positive, concrete (not abstract), and realistic.
- Keep a **drinking/use diary** ("self-monitoring" to raise awareness of AOD use amounts, patterns)
- **"Sobriety sampling**": Individual agrees to trying abstaining from AOD use for a short time (e.g., a week)
- Rewards and celebrations for attainment of even small positive steps
- **"Functional analysis** of antecedents": Individual learns to recognize internal or external cues that trigger cravings
    - Internal triggers include thoughts and feelings (particularly distressing ones)
    - External triggers include items, people, places, and activities associated with AOD use
    - Cravings are inevitable at first, usually last only a few minutes, and can be coped with with planning.
    - New medications can reduce cravings and relapses significantly [72]
- Learn alternative coping skills

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[69] Cognitive-behavioral treatments are more effective than relationship-enhancing or insight-oriented therapies for people with lower cognitive abilities or antisocial or sociopathic personality disorders.
[70] "Cognitive therapy interventions that are focused on identifying and modifying maladaptive thoughts but do not include a behavioral component have not been as effective as cognitive behavioral treatments" (21, 95, 96).
[71] Even if abstinence is the ideal goal, smaller "interim goals" or "sub-goals" are positive steps toward change (8, 63, 73, 75).
[72] APA 2001, and see Supplement.

- Avoid high-risk situations
- Employ new cognitive and behavioral alternatives to use[73]
- Stress management, relaxation
- Coping with feelings

Social skills training

- Learning skills for forming and maintaining interpersonal relationships, assertiveness, and AOD refusal.
- Behavioral therapy with significant other[74] and/or family therapy (12, 98, 99, 100, 101, 102, 103)
- Group therapy to allow for feedback, role-playing, and learning to express thoughts and feelings
- Employment assistance
- Having a job is one of the major factors in successful recovery. (104, 105, 106, 107)
- Advice and help with developing AOD-free social and recreational activities
- Relapse prevention: understanding risks for relapse and coping strategies to avoid relapse

Contingency Management

Some treatment methods include rewards and/or negative consequences (usually incarceration) for specific behaviors. These are called **"contingency management"** programs, meaning that the individual makes behavioral choices knowing in advance the consequences ("contingencies") of their behaviors. One study showed that alcoholics with antisocial personality disorder did best with contingency management in which they could earn more control over treatment choices {Brooner, 1998 #359}

The most effective treatment method for people addicted to cocaine is "**voucher programs"** in which participants can earn (with "clean" urine tests) up to, e.g., $1600 - $2000 in retail vouchers (or cash) over 3 months. (95, 108, 109, 110, 111) Similar reward systems have proven effective in many mental health and AODA treatment venues. They are currently being researched for alcoholism.

Community Reinforcement Therapy

Community reinforcement therapy recognizes that "to stop using drugs and alcohol, people must have something equally powerful to look forward to that will fill their time." (111) Community reinforcement helps the person obtain rewards in socializing, recreational activities, family

[73] "Individuals who report more frequent use of cognitive or behavioral strategies aimed at problem solving or mastery ("approach coping") typically have better drinking outcomes than those who rely on staying away from high-risk situations ("avoidant coping") (21)

[74] Studies show that couples therapy with spouse/significant other improves treatment outcomes, and that the most effective couples therapy has a behavioral focus and focuses on improving the relationship, not merely on the AOD use (21, 97).

relationships, and employment. The person is helped to set and attain goals in each of these areas. Families and significant others are involved in therapy as well.

Part II – Supporting Self-Help Strategies

As noted above, many self-help strategies (for mental health and AOD problems) are derived from formal treatment methods. You'll want to suggest these as options for people. Since almost half of people recover without formal AODA treatment and about 50% drop out of formal AODA treatment, it's not necessarily bad when someone declines AODA treatment. The person might still reduce their use and/or harm from use. They might do this on their own, or they might need some advice and support from Partnership staff. When the member has serious AOD problems, part of negotiating harm reduction will include asking them to at least try some of the self-help steps.
Following are some of the self-help strategies and how you can support members' use of them. No matter which method(s) are used, research shows that follow up (even brief telephone follow up) is very important to success (8).

12- Step Programs

Since 12-Step Programs have proven to be as effective as formal AODA treatment (112) you'll always want to recommend them to members and families.

- Offer to help arrange or provide transportation to meetings.
    - Even if special transportation is needed, it's cost-effective to reduce AODA![75]
    - It might be easy to find volunteers (even among staff) who'd be willing to give members rides to meetings [76]
- Help people find special meetings that will suit them. There are meetings for women, smokers, non-smokers, men, lesbians and/or gay men, etc. Finding these can make all the difference in someone's success. (Contact local mental health or AODA providers to ask what's available in your area.)
- If you've never been to an AA meeting, consider going, so that you can discuss it more knowledgeably with members. (If you're embarrassed because of the stigma around AODA, experiencing that can help you empathize with members more.) "Open" meetings welcome visitors, while "closed" meetings do not.
- People can start groups themselves. Ideally, Partnership members might choose (with some encouragement) to start peer groups that agencies could support by providing transportation, beverages, and a comfortable meeting place.
- Always recommend Al-Anon (or Al-a-Teen) for family members of someone with AOD problems.

[75] See Chapter 2 for statistics of costs and functional impairments caused by AODA.
[76] There need be no boundary violations if the staff is not directly involved with the consumer's services and if neither party discusses Partnership-related issues.

- There are now extensive self-help and 12-Step resources available on the Internet. (Some are listed in the Supplement.) Some members (or families) might prefer "cyber meetings" and chat rooms. You might even provide trips to the library for computer access to these resources.

Behavioral Strategies

When members are receptive (i.e., not resistant), you'll tell them of various ways that they can begin to deal with their AOD problems. Following are some options from which they might choose:

1. Drinking Diary (or Drug Use Diary)

For some people, a good first step is to **pay more attention** to their AOD use by writing down what they drink each day. Many people are surprised to discover how much they really drink (or use) over the course of a week. Sometimes that alone inspires people to cut back, especially if they're exceeding recommended upper limits. For people trying to save money, adding up the costs of AOD per week and month might motivate them to reduce or quit.

Some drinking diaries include space to describe the situations when they drank or used. This can then used to help the person think about their options in various situations. Diaries can help people move from vague generalizations like "I'll cut down" (which doesn't usually work very well) to more specific changes like "I'll stop drinking at home in the evenings, but still want a glass of wine when I go to a restaurant."

2. Setting Goals

The individual decides a specific goal (on own or with suggestions)[77] and writes it down. Research has shown self-determination to be the major factor in whether people will keep their goals. This is true whether the goal is abstinence or reduction, and it is true regardless of the presence of AOD dependency. When people set their own goals, they are more likely to keep them. If you suggest a goal, you'll want to be sure the member agrees to it, then you reflect it back as what they have chosen.

"Prescriptions"

One effective strategy is for a physician or nurse prescriber to actually **write a prescription** limiting alcohol intake. This strategy has shown to be effective for some non-dependent drinkers. The strategy relies on the authority and healing role of the prescriber, which does influence many people. The prescription should be very clear and direct. It might say, for example, "No more than 2 drinks per day to avoid med interactions." You might suggest that the member hang it on their refrigerator or some other visible spot as a reminder.

3. Brief Trials

The individual agrees to "just try" abstaining from AOD use for a short time, e.g., a week.

(In the AODA field this is called "sobriety sampling.") This applies mostly to non-dependent people; people with dependency will need assessment and treatment of withdrawal. This is usually presented as an option for the member to just see how they

[77] Even if abstinence is the ideal goal, smaller interim goals are positive steps toward change (8, 63, 73, 75).

feel after a week of not drinking or using, to see how it goes. This will expose particular barriers and rewards of change, which can then be addressed.

4. Identifying "Cues" and "Risky Situations" for Relapse Prevention

Most self-help workbooks go beyond a simple drinking diary to have people consider the thoughts and feelings, people, or settings that "make them feel like" using AOD. (These are "cues" or "triggers.") They learn by this to recognize how much of their AOD use is in reaction to some internal or external trigger. You can then help them explore other ways to respond to those cues, or to avoid them.

5. Learning alternative coping skills

People who use AOD in response to stress or distressing emotions will need help learning and practicing new ways to cope with those feelings. Relaxation, physical exercise, socializing, calling a friend, going to a movie, taking a long bath or shower, playing with a pet—these are just a few of the ways people can cope with uncomfortable feelings. Many people need reassurance that their feelings (especially loneliness) are normal, universal for all humans. Long-term care staff can offer this, plus can help people obtain medications if needed for, e.g., anxiety, depression, insomnia, or physical pain.

6. Social Skills Training

Some members will need help practicing ways to refuse drinks or drugs. You can offer them some "scripts," such as "My doctor told me not to drink," or "I can't drink with my medications." You could even role-play with them, playing a friend who encourages use, and helping the member practice being assertive. Again, ideally, the member will accept formal AODA treatment that provides more in-depth assistance of this type. But these are also fairly basic methods of self-help and peer support, such that non-AODA providers can reinforce them as well. Opportunities for these helpful conversations often arise in the context of long-term care.

7. Rewards

There is great opportunity for long-term care programs to develop innovative reward systems for their members (and families). These needn't be bureaucratically administered; in fact, rewards must be appropriate to each individual. Mental health case managers routinely use rewards. For example, a case manager might say, "I'll come back next Wednesday at 10. If you take a shower before then, I'll take you out for an ice cream." The rewards are always "extras," and there is no punishment involved. If on next Wednesday the client has not showered, the case manager simply says nonjudgmentally, "You didn't shower, so I can't take you out for an ice cream today. Do you want to try for next Wednesday?" (Of course, the staff would provide more interventions if necessary; the point is that case manager continues to come back and is consistent and nonjudgmental.)

Mental health agencies have developed numerous reward systems that work well. Special trips out for coffee or lunch, or to a park, a movie, or swimming, can be effective motivators. People can earn **retail vouchers**—movie passes, gym memberships, gift certificates for various stores and restaurants, hotel stays, gas money, etc. Be creative;

involve staff of various levels who might enjoy some fun as well. **AODA evidence indicates that all the time and money you put into effective reward systems will be repaid at least four-fold**.[78]

[78] This is a very conservative estimate, since Partnership members do differ from more general populations. In general, "every $1 spent on treatment yields a return of up to $7 in a reduction of drug related crime and criminal justice costs. When adding savings related to health care, the savings exceed costs by a ratio of **12:1** *(NIDA, Principles of Drug Addiction Treatment, 1999).*

Part III—Adapting MET for "Self-Medication"

As noted in Chapter 4, if a member is using AOD to try to relieve an underlying problem such as pain, spasms, insomnia, or anxiety, you will likely be more successful if you address the underlying problem as well as the AOD use. In doing brief interventions, you will

1. Provide **Feedback** about the real effects of their use and any risks or problems it creates.
2. Acknowledge that they have **Responsibility** to choose their AOD use and how to manage their underlying problem. Say that you will provide or help them find healthcare providers who will **share the responsibility** of addressing their underlying problems.
3. Provide **Advice** not only regarding their AOD use, but also regarding their underlying problem.
4. Present a **Menu of Options** for them not only regarding their AOD use, but also regarding various ways to address the underlying problem they're trying to solve with AOD. Make a commitment to help members obtain high quality healthcare to address the underlying problem.
5. Express **Empathy** not only regarding their AOD use, but also regarding their underlying problem.
6. **Support self-efficacy** with a "can-do" attitude and by offering **pragmatic supports** not only regarding their AOD use, but also regarding their underlying problem.

Similarly, when the member is consciously using AOD to self-medicate, you'll need to adapt your MET to incorporate the underlying problem. You are encouraging the member to change not only their AOD use, but also to change the way they manage the underlying problem. This will require extra support for the underlying problem as well as for AOD behavior changes.

A prime example is chronic pain.[79] The use of opioids for chronic pain is controversial in the U.S.{Adams, 2001 #35;AAPM, 2001 #402;Leboeuf-Yde, 2000 #139;Brown, 1996 #49}. Yet it is recognized that pain (acute or chronic) is inadequately treated in the U.S. There are some methods found to help improve pain control and reduce drug-seeking/pain control-seeking behaviors. The following methods apply particularly to chronic pain, but could be used for any other problem for which a member is self-medicating.

1. Provide full pain assessment, referring to pain specialist if member agrees
2. Provide or facilitate regular frequent visits with a healthcare provider to focus on the pain.
    - This is important to provide positive reinforcement (attention and help) regardless of the member's pain level on that day.
    - Visits should include use of pain scales functional measures
3. Provide clear explanations of expectations and plan. Negotiate plan to reduce power struggles. Write them in a "contract" or plan that member signs. Examples of things to include in plan:

[79] A study of Wisconsin primary care clinics showed that of patients receiving chronic opioid treatment, 67% were women (average age 53). "The most common pain diagnoses included lumbar/low back (44%), joint disease/arthritis (33%), and headache /migraine (28%)." %). Depression/affective disorders were reported in 36% of the patient charts, anxiety/panic disorders (15%), drug abuse (6%), and alcohol abuse (3%)." {Adams, 2001 #35}

a. Physician/nurse practitioner pledges to provide individualized treatment for pain relief in accord with best practices
b. Member will be seen by physician/nurse practitioner every ___weeks to review pain relief measures and plan.
c. Member recognizes that medications alone cannot provide adequate pain relief, and that the member must engage in pain relief strategies as well
d. Pain medications will be tailored to individual need and according to standards of medical practice. Doses will be adjusted based on functional status and pain scale reports in regular office visits.
e. It is easy to use pain meds for reasons other than pain relief, including for relief from unpleasant feelings. All parties accept responsibility for open discussions of such issues. Alternative coping mechanisms will be explored with the member, so that pain medications can be most effectively used for pain control.
f. Member agrees to use only one pharmacy and only one physician/nurse practitioner for pain relief, and to contact the primary prescriber with problems

The point is to provide structure and on-going support.

Following is an example of a more "acute" negotiation in which you focus both on the member's alcohol use and the underlying problem she's trying to medicate (erroneously) with alcohol:

> ***Barbara*** *is a fairly new member who lives alone. Her personal call worker calls you to report a lot of beer and liquor bottles in the recycling container the past few weeks. You speak with the other PCW, who says that Barbara does appear to be hung over many mornings. Barbara's intake assessment indicated that she rarely drank more than 2 drinks at a time or more than 3 times a week.*
>
> *You make sure Barbara understands the harms from drinking so much, and you do advise her to cut back or quit. (How to do this is explained in chapters 4 and 5.)*
>
> *BARBARA: Starts to cry…Oh, I just can't stand it, I get so lonely and I just these panic attacks, I just can't stand it…The nights are worst, it's like a nightmare. I feel so stuck and hopeless. I can't stand this, I just want to die; it's so awful.*
>
> ***You're tempted to say****: Well, I'm here to talk about your drinking. You have to stop.*
>
> ***Instead****, you recognize severe anxiety and depression, in addition to an increase in drinking. Right now Barbara seems to be using alcohol to cope with severe anxiety, depression, and loneliness. You do not focus only on the drinking. You focus on her overall—her suffering, what's triggered it, when, what helps; what does she need right now, is she suicidal, is she safe, will she contract with you to be safe; can you help her get an anti-anxiety or sleeping pill today, and in to a mental health prescriber soon? After discussing all that with her, you teach Barbara some relaxation techniques and sleep hygiene recommendations. Then you suggest a plan that Barbara agrees to:*

YOU: So, you said you won't drink any alcohol tonight. You'll take the anti-anxiety med at 6 o'clock, and you'll take your sleeping pill at 9. Do you agree?
BARBARA: Yes.

Later on you'll discuss the excessive drinking with her, to help her learn better coping skills. For now, you are also addressing what she experiences as a major problem, which is her anxiety. [80]

Part IV – Organizational and Implementation Issues: Working with AODA Providers

Most members will need and want your help in finding AODA treatment providers. Each agency will need to develop relationships with several local providers and share information with staff. Staff can provide brochures or describe AODA providers' approaches to members to help members make an informed choice. Depending on the member, they might call themselves, you might make the referral, or you might schedule the appointment and arrange or provide transportation. Two points to keep in mind: (1) Offer all supports (pragmatic and emotional) that are needed to facilitate AODA treatment, and (2) continue to provide support and follow up regarding their AOD use.

All four Partnership agencies reported difficulty finding local AODA providers. Many now have waiting lists or are only private-pay, such that it may be difficult to find **any** formal treatment, let alone one with a particular desired philosophy.[81] This manual focuses on what Partnership staff can do to improve outcomes for members who **refuse** abstinence and formal AODA treatment. Because of that focus, methods that tolerate non-abstinence have been stressed, as that is what **you** need in your most challenging cases. This does **not** mean that abstinence-based AODA treatment is to be rejected! Your interventions will hopefully help a member (or family member) choose to abstain, in which case they will have no goal conflicts with AODA providers. Traditional AODA treatment **does** work for many people; even more so if "success" is defined as reduced use and/or reduced harms (rather than only abstinence). (See section on quality monitoring of AODA providers below.)

Some members may not want traditional abstinence-based AODA treatment. You may need to negotiate some middle ground with AODA providers to serve these members. ("You" may be interdisciplinary team staff advocating for a particular member, or a provider network developer or contract administrator.) It is often easier to **negotiate "special adaptations" for one member at a time** than to try to argue for general changes in philosophy and practice. So, e.g., you might validate an AODA providers' rule that intoxication is grounds for eviction from that day's group therapy, but ask that this particular member not be evicted from AODA treatment if they lapse/relapse. A potential strategy is to appeal to the providers' helping impulse, asking

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[80] Treatment of major mental illnesses should occur concurrently with treatment for AODA, ideally in an integrated approach. {Minkoff, 2001 #635}, {Laudet, 2000 #223;Herman, 2000 #245}

[81] More systems changes are needed to cross-train AODA providers in long-term care issues. Fortunately, systems changes have already begun in Wisconsin to move toward more consumer-focused collaborative treatment models. Wisconsin resources are listed in the Supplement.

them to help you, the long-term care provider who will stay with the member whether AODA treatment "fails" or "succeeds." This strategy might help them feel justified in bending their rules to help you (whereas their training is to keep firm rules to help clients, and arguing for "harm reduction" may generate resistance from them).

You could also inform AODA providers of federal and state resources for the more recent evidence-based best practices that stress improved outcomes over abstinence.[82]

AODA Providers and the ADA

All four Partnership agencies reported difficulties in finding AODA treatment resources for people with physical disabilities or mild cognitive disabilities. AODA providers are required by the Americans with Disabilities Act to provide reasonable accommodations for people with disabilities in need of AODA services. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) published a book to guide AODA providers on serving people with physical and cognitive disabilities. (51) [83] You might use this information as you negotiate with local AODA providers. In reality, the ADA is rarely enforced, and Partnership agencies will probably need to work with local and state stakeholders to foster the development of more AODA (and mental health) services for people with long-term care needs.[84]

Quality Assurance Oversight of AODA Providers

Provider network developers and contract managers could use this manual as a guide for developing performance standards and outcomes measures for AODA providers with whom the agency contracts. Feedback from members, families, and staff should be regularly obtained and used in contract negotiations and for QA/QI.

As noted above, traditional AODA treatment may be fine for many members. You may, however, want to include some performance standards that might be new for those providers. These could include, e.g., that the AODA provider accepts over 95% of your referrals without delay, or that members' specified outcomes improve from treatment, even if abstinence is not attained.

Agencies should definitely keep in mind that **brief therapies** are often as effective as longer therapies: "Brief interventions and brief therapies have the appeal not only of being brief but also of having research backing that supports their use."[85]

The evidence-based interventions presented in this manual are adequate for non-AODA providers to do "brief assessments" and "brief interventions" for AODA. Full assessments by an AODA professional form the basis for formal AODA treatment. It is not clear that it is cost-effective for Partnership agencies to purchase AODA assessments for any member with apparent AOD problems, unless the member wants and needs AODA treatment. Using the nonjudgmental

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[82] Some of these are provided in the Resources list in the supplement to this manual.

[83] See the Supplement for further information.

[84] Complaints about AODA providers can be reported to the Wisconsin Bureau Quality Assurance at 608- (608) 243-2087 or Plicmhaoda@dhfs.state.wi.us

[85] (8). Brief therapies have been less thoroughly researched than brief interventions *(ibid)*.

methods and screens presented here, Partnership staff will usually be able to determine the likely extent of a member's AOD use well enough to provide brief interventions, brief motivational enhancement techniques, and harm reduction. Hopefully these interventions will encourage the member to agree to formal AODA assessment **and** treatment.

Conclusion

This chapter presented the major types of formal AODA treatment methods. More information is available in the Supplement. Many of the methods have been adapted into self-help programs. Partnership staff are not expected to provide full AODA treatment or therapy. (Most have neither the time nor the qualifications.) But with members who refuse AODA treatment, there are some simple self-help methods that you can teach members and support them in using. In all cases, follow up—on-going engagement through all the stages of change—is necessary for success. Such follow up is likely to entail more frequent visits than are now made. Agencies will need to keep the "big picture" focus of the overall cost-effectiveness of AODA interventions in improving outcomes, even if the member does not abstain.

QUIZ FOR CHAPTER 6

1. Which of the following are among the most effective treatments for AODA?
    a. Brief interventions using FRAMES
    b. Motivational Enhancement Therapy
    c. Alcoholics Anonymous, Narcotics Anonymous, or other 12-step peer support groups, even without professional AODA treatment
    d. Cognitive-behavioral therapies
    e. All of the above

2. What is one of the most successful treatment methods for cocaine addicts?
    a. Rewards system
    b. Imprisonment

3. What are some of the basic components of trying to change a behavior?
    i. Understanding when I do that behavior
    ii. Understanding why I do it
    iii. Finding other ways to get what I want
    iv. Having hope and support from other people, even if I "relapse"
    v. All of the above

4. You've already done FRAMES and Miriam is not yet willing to seek formal AODA treatment. Miriam asks, "All my friends drink and smoke pot; how am I going to see them and not do it, too?" How would you answer?
    a. Miriam, you'll just have to not see them at all.
    b. It's always hard to cut back or quit if your friends all use. You could say, "It makes me sick because of meds I take," or "My doctor said I can't." What do you think?

5. Which of these are behavioral strategies you might offer for members to choose from?

    a. Keep a drinking diary, to notice how much, when, and perhaps why one drinks
    b. Set a quantity/frequency goal for reduced use
    c. Quit completely
    d. Try quitting for just a brief time to see how it goes
    e. All of the above

6. Which is correct when you are helping someone who has decided to quit AOD use?

    a. We should not mention cravings, because that will discourage them
    b. We should not mention cravings, and hope they won't have any
    c. We should say that cravings are normal and to be expected, that they only last a few minutes, usually in response to cues or feelings, and that it helps to have a plan for what to do when they occur.

7. Which of the following are standard services in the AODA treatment field?

a. Social skills training—e.g., how to refuse AOD, how to have fun without AOD
b. Therapy with significant other and/or family
c. Learning new ways to cope with difficult feelings
d..All of the above

8. Which of the following therapies have been adapted to (or derived from) self-help strategies?

a. Voucher programs
b. Learning new ways to cope with feelings and thoughts
c. Strategies to avoid relapse
d. b and c

9. What helpful things do peer support groups like AA (Alcoholics Anonymous) provide?

a. New helpful ways to think such as "One day at a time," "This too shall pass"
b. Strategies for relapse prevention
c. Acceptance, a group to belong to
d. All of the above

10. True or False: _____ Studies show that for every dollar spent on AODA treatment, five dollars are saved in health care costs.

Quiz Answers:

1 e, 2 a, 3 e, 4 b, 5 e, 6 c, 7 d, 8 d, 9 d, 10 True

Chapter

7

Chapter 7 – Setting Agency Limits

Introduction

In those "toughest cases" in which members continue with very harmful AOD use, you will do **harm reduction and AODA interventions to reduce harm and improve outcomes** as much as possible. In addition, you may need to set some specific **limits** on how much your agency is willing or able to do for a member who continues to engage in harmful behaviors and/or to make great demands of agency resources. This chapter covers that.

First, to distinguish setting limits from restricting members' liberties (i.e., their freedom): You set limits on your own behaviors as staff and agency, because you cannot really control (set limits on) someone else's behaviors. You can try, of course, through threats, pleading, bargaining, punishment, etc.; but you cannot force them to comply without restricting their liberties (their freedom). In long-term care, agencies frequently have to set limits and restrict members' liberties to various levels.

Part I – Setting Agency Limits

Limits (upper limits) are the bounds or quantities beyond which something cannot proceed.

In human service systems, limits are based partly on government policies and regulations. In the U.S. there is no consensus—among federal agencies, states, or the public—on many of the limits that are needed to run human service agencies. [86] As a result, agencies must set their own limits in order to function.[87] Not all limits can be set in advance. Some limits must be made in

[86] Different states have different policies on the upper limits of services provided under Medicaid card and waiver services. Medicaid "waiver" programs use funds that would be used for nursing home placement to provide community-based long-term care services instead. Participants in Medicaid waiver programs must meet Medicaid eligibility for nursing home placement (the definition of which varies among states). Wisconsin's Medicaid waiver programs include, e.g., COP and CIP–the Community Options Program and the Community Integration Program, respectively. Some states, for instance, limit in-home services to the cost of nursing home placement for the same individual. Other states determine where a person will live based on the level of help that they need.

[87] Because of this, agencies' limit setting involves a complex balance of the agency business interests and staff's interests (such as safety and workers' rights) with members' and families' interests. Agency limits reflect a particular agency's priorities and philosophy at a particular time. In practice, once limits are set, they often become traditions ("common-

individual cases, usually when a member or family places extraordinarily high demands on agency resources.

Long-term care is complicated enough; adding AODA to the mix only complicates it further. As with all complexities, it helps to separate different issues as much as possible and to have a standardized process in which you ask the right questions in the right order, and some basic guidelines to help you avoid common missteps.

Agencies set limits on services based fundamentally on (1) resource allocation, and (2) levels of risk.[88] When AODA is involved, some additional considerations are required. Let's look at these in order from basic steps to a more specific process of setting limits involving AODA.

Four Basic Steps For Limit Setting Involving AODA

1. Do Brief Intervention, MET, and Harm Reduction with the member

2. Ask about member's (or family's) perspective and expectations, and discuss those.
   Perhaps they had no idea their expectations are excessive. Perhaps their explanation will convince you that their requests are, in fact, a reasonable and cost-effective way to meet the member's outcomes. Perhaps misunderstandings or power struggles will become evident so that you can resolve them.

3. Attempt joint problem solving and/or try to negotiate a compromise.

4. Only after the above steps have been done, consider whether any specific limits need to be set. Go through the "Limit-Setting Checklist" listed below.

Example of Using the 4 Basic Steps For Limit Setting Involving AODA

Paul *has been evicted for AOD use and loud partying 3 times in the past 7 months. His interdisciplinary team staff have had to spend many hours responding to each of these crises, as Paul uses a wheelchair, has a catheter and a central IV line, and needs daily assistance with transfers, toileting, bathing, etc. The agency has put him up in hotels for several weeks until they could find him a new apartment and help him move. Paul has no cognitive impairments. Paul is in Precontemplation and is happy with his present use of alcohol, pot, cocaine, and other street drugs as he can get them. He has refused formal AODA treatment, and has been unwilling to reduce his AOD use.*

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sense" assumptions) of that particular agency. They may be written as official policies. A learning organization is one that is willing to re-examine its traditions to continually improve its ability to meet its mission.

[88] While the two are often conflated in practice, they should be distinguished. In Wisconsin's consumer-outcomes-focused community-based long-term care programs, consumers are not placed into more restrictive settings (such as institutions) based solely on service cost comparisons. Rather, the criterion is the most cost-effective way to meet the consumers' individual outcomes. See www.dhfs.state.wi.us/LTCare for more information on this principle of consumer-centered long-term care and this resource allocation decision method based upon it.

Paul's team needs to set some limits on how much they will help him after evictions. His interdisciplinary team goes through the 4 Basic Steps For Limit Setting Involving AODA.

Below are several variations of how situations like Paul's might play out.

"1. Do Brief Intervention, MET, and Harm Reduction with the member"

Several different staff have done Brief Intervention, MET, and Harm Reduction with Paul. (Per the team's request (and summary guideline[89]), Paul's MD did brief interventions as well.)

> ***Variation A:*** *Everyone's been so focused on trying to get Paul to* ***abstain*** *that no one thought to do harm reduction specifically around* ***preventing evictions****. So now, the team shifts focus to consider where Paul might live without being evicted, even if he and his friends continue their loud partying. Staff explain to Paul that they can not continue helping him so much after evictions, and ask him to negotiate and problem-solve with them.* ***Several possibilities arise****: Paul could move into his rowdy friends' house, he could rent a small inexpensive house (with a roommate if financially necessary) where neighbors would not be disturbed, or he could rent a place on a farm with no close neighbors. If one of these options works, the eviction problem is solved, and the team can continue to do brief interventions, MET, and harm reduction for his AOD use (and help Paul find a job and other interests.)*

"2. Ask about member's (or family's) perspective and expectations, and discuss those."

Previously, no one's thought to ask Paul his view. Now they do.

> ***Variation B:*** *It turns out Paul had no idea how upset his team staff were. He had "never really thought about it," he said. He thought the staff and agency got paid more when they helped him more. Because he was asked his view first, he was more open to listening to the staff's views.*

> ***Variation C:*** *Paul says,"So what, other guys have wives to clean up their messes, I have you. It's your job." Given this,[90] Paul is likely to power-struggle with even the most skilled females, so the team sends a male to talk to him. (This might be a team member or a supervisor.) Paul tells the male (Kurt) essentially the same thing. Kurt explains managed care and explains that Paul is using up way too much of staff's time; that he's taking more than his fair share of scarce resources. Paul says, "Fair, hell, I don't care. You have to do it. You'd look real bad if a guy like me gets homeless." [The point here is that appeals to moral concepts like fairness or personal responsibility are usually not very effective.]*

"3. Attempt joint problem solving and/or try to negotiate a compromise."

This may go beyond harm reduction done in Step 1, as the following indicates:

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[89] Provided in the Supplement.

[90] Alcoholics are 21 times more likely to have personality disorders. Paul seems to have some mental health needs in addition to his AODA. Ideally, an integrated AODA/MH provider could be found for him if/when he is willing to try such treatment.

Continuing from Variation C above, Kurt attempts to engage Paul in a win-win negotiation mode. He asks, "Paul, what do you want?" and tries to find common ground—namely, that evictions are hard on both Paul and his team. (Paul wouldn't admit to women that he's been scared and embarrassed.) From here, Paul is more willing to talk details about how he might avoid getting evicted again, or at least less frequently. Paul also says he could ask friends to help him find new apartments and help him move, to reduce the burden on staff.

"4. Only <u>after</u> the above steps have been done, consider whether any specific limits need to be set. Go through the "Limit-Setting Checklist."

If Paul remained completely uncooperative, you apply the Limit-Setting Checklist (explained below) as a guide to set limits.

Limit-Setting Checklist

When it is time to consider setting some limits with a member or family, go through the following checklist. (This list assumes that the member has no cognitive impairments.[91])

1. Consider whether you set similar limits for members with **other chronic conditions** such as diabetes or high blood pressure. If not, what facts justify treating this situation differently?

2. Consider how you can set and present these limits in a way that is not putting you in a parental or authoritarian role.

   As with all the other AODA interventions you've learned, one of your goals is to try to avoid triggering more resistance from the member.

3. Whenever possible, limits should be **negotiated**, rather than decided unilaterally by the agency. (This is not always possible.)

4. Whenever possible, the member (and/or family) should be **informed of limits in advance**, so that they can make informed choices based on them.

5. Limits not directly related to a behavior should not be set in response to the behavior (i.e., as punishment for that behavior).

   Example: "Why should we help you [do something enjoyable] if you won't stop your AOD use?

   Note: **Rewards** can be unrelated to the behavior and can be withheld if not earned. But rewards should be "special treats," i.e., beyond covered services, and agreed upon in advance.[92]

6. Healthcare services should not be withheld based on the reason they are needed.

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[91] See separate agency guidelines on addressing members' risk-taking.

[92] See Chapter 6 for more discussion on rewards.

For example, healthcare providers have professional and ethical requirements to treat, e.g., a wounded person, regardless of the fact that the person was wounded while committing a crime.

7. In-home assistance with ADLs and IADLs[93] necessary to ensure members' needs and safety should not be withheld based on the reason they are needed.[94]

8. Beyond this, limits will be set based on (a) the agency's resource allocation policies and/or (b) the agency's guidelines for addressing member risk-taking.

[93] "ADLs" are activities of daily living—bathing, grooming, dressing, eating, transfers, and toileting. "IADLs" are instrumental activities of daily living—meal preparation, medication management, money management, and transportation.

[94] Family caregivers' unavailability to provide cares due to AOD use is discussed in Chapter 9.

Example
Sarah *has diabetes, fibromyalgia, arthritis, obesity, and depression, and is alcohol-dependent. Sarah lives alone, uses a wheelchair for longer distances, and is on SSI. Partnership provides her with bus passes so that she can go grocery shopping and do her errands. It is discovered that Sarah also purchases liquor during these bus trips. Some team members propose stopping her bus passes for this reason. They argue that Sarah is abusing the bus passes and that allowing this would be enabling her addictive behaviors.*
Analysis
Stopping Sarah's bus passes for this reason would violate almost all of the items in the above checklist.[95] *(1) You do not withhold bus passes for members with other chronic conditions, e.g., a diabetic who buys sweets. (Beware the moral model "sneaking in" with AODA!)*
(2, 3, and 4) *This would be a unilateral decision by the team, giving Sarah no chance to make informed choices about it. She is likely to perceive it as parental, authoritarian, and unfair.*
(5) *Bus passes were included in Sarah's service plan to meet her outcomes of community participation and independence and nutrition. Bus passes for Sarah are not directly related to Sarah's drinking alcohol; she would find another way to get alcohol. Stopping bus passes would not stop her from drinking alcohol.*
(8) *The team could consider whether stopping the bus passes is justified based on resource allocation or risk-taking guidelines. It is unlikely. The bus passes probably remain a cost-effective way to meet Sarah's outcomes of community participation and independence and nutrition. Risks to Sarah result from her continued drinking, not from the bus passes.*

More about ***(5)*** *and* ***(8)****: If the team feels that Sarah's access to alcohol should be curtailed by restricting Sarah's liberties, that would be done by suggesting a more restrictive setting as discussed below. It would not be done by "punishing" her by removing a covered service that does cost-effectively meet Sarah's needs and outcomes as identified on her service plan.*

Setting Limits to Preserve Staff Rights and Safety

Every profession, agency, and individual staff must have established limits and boundaries to preserve staff's rights and safety. When members' or families' AOD-related behaviors create safety concerns for staff, an agency may need to limit what it will provide in that home. It is rare that situations are clear-cut, however. If someone in the home has been violent or threatening toward staff, it is an unsafe setting. If there is heavy drug dealing with weapons and violence evident, it is an unsafe setting. Most of the time, however, the situation is less clear. Chapter 8 discusses the extent to which notions of "safety" are culturally specific; agencies must be very clear that their decisions around safety do not reflect cultural biases. The majority of safety

[95] This analysis assumes that Sarah is using bus passes to get groceries and other errands done, and in addition also buys alcohol. If Sarah used bus passes for nothing else except to obtain alcohol, the analysis would be different.

concerns involving AODA will involve levels of risk for possible harms that have not occurred but may. Use of alcohol and some street drugs is very strongly associated with acts of violence. The details of each situation must be considered in order to assess the level of risk to staff.

Having assessed some level of risk, the staff and agency must decide how to respond to it. There are two important considerations here: (1) A **member-centered** focus should be maintained, and (2) various **options** to preserve necessary in-home services should be considered.

> ***Example***
> *A long-term care agency sets a policy of not providing any home visits after 7 PM to certain high-risk neighborhoods. A general policy like this does not allow for member-centeredness, because the member's/family's particular needs are overridden by the general policy. Obviously staff safety is a priority. The agency could explore various options to meet the priority of staff safety without overriding the agency's other priority of member-centered services. Private security escorts could be hired; staff could make visits in pairs; in some cases, male staff may feel confident making evening visits. The safety concerns could be problem-solved with the member and family. Some agencies have found family or neighbor volunteers to meet them at designated times and escort them into the member's apartment. Some have collaborated with neighborhood organizations (e.g., religious communities or neighborhood centers) to ensure caregivers' safety.*

In other situations, you set limits not because of staff safety, but because of member's safety.
In these instances, the **limits** that you set involve your agency's **capacity to serve** the member safely at home. You may recommend a more structured living situation, perhaps one in which the member will not have access to AOD. Y our proposal may be based on cost-efficacy (it's the most cost-effective way to meet the member's outcomes) and/ or on safety (it's the only way to ensure the member's safety). Congregate and more structured settings such as group homes, adult family homes, or nursing homes, may be **more restrictive** than the member's preferred living situation. In these instances, you are proposing restricting the member's liberties in order to meet their health and safety needs. This is a form of harm reduction that we'll discuss next.

Part II — Restricting Members' Liberties

The issue of restricting people's liberties for reasons of AODA is complicated. Wisconsin courts have held that competent adults have the right to drink themselves to death if that is their fully informed choice. On the other hand, Wisconsin statutes include court-ordered treatment and protective placements for persons incapacitated by substance abuse. Also, in long-term care it is not uncommon (albeit unofficial) for elders to be placed in nursing homes primarily in order to prevent them from accessing alcohol.[96] There is no clear consensus on this matter in Wisconsin, particularly across the various systems (e.g., long-term care, mental health, AODA, and legal

[96] They must also, of course, have other health conditions requiring nursing care.

systems). On the other hand, since there is some evidence that court-ordered AODA treatment may be effective,[97] court orders might be an appropriate intervention for some individuals.

Recommending a More Restrictive Residential Setting

Partnership agencies may recommend **more restrictive residential settings** if other options have failed to ensure minimal health and safety for the member. This is essentially a form of harm reduction. The decision to move members to more restrictive settings is one that Partnership staff have always made by weighing the member's preferences with health and safety. When the equation involves AODA, there are two principles to keep in mind:

1. Ideally, you will try several different approaches with the member before raising the issue of a more restrictive setting.

These repeated attempts at harm reduction may occur over weeks, months, or even years, depending on the circumstances.

2. Ideally, the member is informed of their options in advance, so that they are able to make some choices.

They may be unable or unwilling to quit or abstain, but they may be able to make enough changes so that they can stay in their homes.

Of course, not all situations are ideal, but you should keep these ideals in mind. The following is an example of using these ideal principles in non-ideal circumstances:

Example

Rico, a 73 year old member with longstanding alcoholism and numerous other health conditions, was hospitalized for an acute problem over the weekend. Rico's physician (and hospital staff) recommend permanent nursing home placement for Rico, mostly to restrict his access to alcohol. Rico's interdisciplinary team disagrees with this plan, because Rico is a new member. Team staff have not yet had a chance to try harm reduction with Rico; Rico hasn't had a chance to make some choices in order to stay in his apartment. The team will help Rico get back home so that more options can be tried and Rico can make informed choices to preserve his preferred living situation. The team does not need to know that Rico will succeed, only that he deserves the opportunity to try.

Seeking Representative Payeeship

If Social Security recipients are unable to manage their finances, individuals or agencies may apply to become the member's "representative payee." "Rep payees" (as they are called) receive

[97] The issue of coerced versus voluntary treatment remains an on-going debate within the AODA field. As noted in Chapters 2, 4, and 5, the AODA field has generally moved toward evidence-based collaborative methods. Fewer authors, mostly in corrections, argue, "[O]ur clinical experience and treatment outcome studies to date strongly suggest that coercion is fundamental to addiction treatment and favorable outcomes from therapeutic interventions" (113). One meta-analysis found some "support for the dictum that legally referred clients do as well or better than voluntary clients in and after treatment," but admitted to "some divergence in findings" (114). This is a complex topic undoubtedly involving many variables for which more research is needed.

the individual's Social Security Income or Social Security Disability Income check each month and are responsible for spending it in accord with law and in the individual's best interest. The member's liberties to spend their own money are restricted when they have a rep payee. They should be allowed to regain control of their money when they are able to manage it again. Rep payeeship (or guardianship) is easy to decide when the person is clearly cognitively impaired. It is less clear when AODA is involved. As noted in Part II A of this chapter, there is no clear consensus on when protective interventions are appropriate for AOD-dependent persons.

Conclusion

There are limits to what human service systems can provide for people. In the U.S., such limits vary widely among states and programs. In practice, limits are set by agencies and thus reflect the particular agency's balancing of multiple stakeholders' interests. When it comes to AODA, long-term care staff have been trapped between the unhelpful dichotomy of "enabling versus abandoning." As with most "ethical dilemmas," the solutions are usually found in the details and in negotiation. This chapter presented some questions and a checklist that long-term care staff can use to set limits appropriately.

Quiz For Chapter 7 --Setting Agency Limits

1. When long-term care staff set limits, what are they doing?

a. Defining acceptable limits beyond which members and families cannot go
b. Stating the upper boundaries of what they (staff/agency) will provide
c. Restricting members' harmful behaviors

2. Limits (upper limits to covered services) are based on which of these?

a. Members' cooperation with service plan
b. Resource allocation guidelines
c. Policies/guidelines for addressing members' risk-taking and for workers' rights and safety
d. b and c

3. Limits (upper limits to covered services) should be set by:

a. Agency administrators
b. Interdisciplinary team staff
c. Interdisciplinary team staff negotiating with the member/family (if possible), with administrators and other agency staff involved as needed

4. An elderly male is admitted to the ER with severe bleeding from his stomach and esophagus caused by alcoholism. He is a frequent visitor to the ER, usually drunk and homeless. What happens? Why doe ER staff treat him?

a. Because they expect to cure his bleeding and his alcoholism, and that he will never drink again.
b. Because they are required by law and ethics to treat anyone regardless of the reason help is needed.

5. What are the ideals to try to meet when possible before more restrictive residential setting is recommended in response to AOD problems?

a. Members should be informed of their options in advance, so they have opportunity to make some changes to stay in their preferred setting
b. Several different approaches have been tried before restrictive settings are recommended
c. a and b

Quiz Answers:

1 b, 2 d, 3 c, 4 b, 5 c

Chapter

8

Chapter 8 – Cultural Competency and AOD Problems

Introduction

Cultural competency is "rooted in respect, validation, and openness towards someone with different social and social perceptions and expectations than one's own" (115). Cultural competency is already part of the Partnership Program; this chapter discusses cultural factors specific to AOD use.

Although some restrict "culture" to nationality and race/ethnicity, the term is now often used in its broadest sense, to include "subcultures" such as age (generational cohort), gender, nation of origin (immigrant status—e.g., voluntary or involuntary, recent or third-generation, etc.), religion, disability status, sexual preference, rural vs. urban, etc. The broad concept of culture is used here, because it more accurately recognizes important variations among groups.[98]

You already know the "cultural differences" across generations, as you know that most elders tend to be more formal, polite, and less willing to discuss personal problems. Much of "cultural competency" discussions present how Many other cultural differences consist of how a given culture

[98] "Race" is a social construct, not a biological reality. Terms like "white," and "Black," etc. are inherently simplistic and problematic because they reify race (treat it as real) and ignore mixed heritage. Terms like "Asian Americans" or "Latinos/Hispanics" ignore significant cultural differences of religion, nationality, etc. (For example, "Asian Americans" comprise some 46 distinct cultures (116), and "Hispanics" at least 3 major groups—Puerto Ricans, Cubans, and Latin Americans). The terms are used here because they are in general use.

Population Rates of AODA

Federal agencies collect copious information on the rates of AOD use among various racial/ethnic groups. If you are interested in those, you can see them on line at http://www.drugabusestatistics.samhsa.gov/. [99]

Rates of AOD use are the percentages of populations (racial/ethnic groups) who use AOD, so they are population data. Population data on AODA rates can be useful in two ways:

(1) To correct misperceptions. For example:
- ✓ Many people think that Blacks use illegal drugs more than whites. In fact, the data shows that the highest rate of illegal substance use occurs among white male college students.
- ✓ Many people think that Native Americans drink more than others. In fact, the data shows that whites have higher rates of binge drinking and heavy drinking than do Native Americans.[100]

(2) To indicate problems that are generally overlooked on the individual level. For example:
- ✓ Data shows that AODA is far more of a problem among elders than anyone had thought (as shown in Chapter 2).
- ✓ Data shows that elderly (white) widowers have high rates of suicide and that suicide is often preceded by drinking alcohol. Knowing this can remind you to assess and intervene early for AOD problems and depression among such men.

For these two reasons, population data can be useful, and some relevant data is presented in this chapter. There are important limits to the use of population data, however. **Population data cannot be used to make any assumptions about individuals or their need for support**. For example, the fact that Asian-Americans and Jews (of any nationality) have the lowest rates of AODA does not mean one can assume that an individual Jew or Asian-American does not have a problem. The population data does **not** indicate that you can skip an AOD screen or fail to be alert for "red flags" of AOD problems in Asian-American or Jewish members. Each individual, regardless of population data or cultural differences, deserves the same level of attention as all others. The fact that a certain population has a high rate of AODA does not mean that AODA is "typical" of that population and can therefore be ignored. Each individual, regardless of population data or cultural differences, deserves the same level of interventions as all others. Notice that individuals deserve the same **level** of attention and of interventions; your attention and interventions will be **adapted** to each individual and their cultural issues. Several examples are provided in later sections. First, let's look at a few basic points relating to cultural and language issues in long-term care.

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[99] http://www.drugabusestatistics.samhsa.gov/ ; http://www.samhsa.gov/oas/race.htm#Tables (51, 117)

[100] 2001 National Household Survey on Drug Abuse, www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/Chapter3.htm

Translation and Interpreters

Federal laws require that clients of health and social services be provided with translators at no charge. In practice it is common for family members to translate, especially in the home. However, the use of family translators may need to be avoided if you need to discuss AOD problems with a member. AODA is such a sensitive and stigmatized topic that many people are ashamed and do not want family to know of it. Elders especially do not want their children or grandchildren to know. (38) While the use of family translators is frequently necessary in home-based services, the need for privacy must be prioritized:

> *The use of family and friends as translators violates the right of privacy of the client…When the children of the client are used as translators, the client may be reluctant to fully discuss certain topics or the translator may have a tendency to speak for the client. Use of family members as interpreters alters the family structure. {NIDDR, April 1999 #636},p. 34*

Some of your members will require interpreters for American Sign Language or signed English in order to participate in AODA peer support groups. The Wisconsin Bureau of Mental Health and Substance Abuse Services is currently organizing AODA trainings for interpreters.

If family members are giving the member alcohol or drugs, then shared conversations may be appropriate. If the family is purposefully trying to abuse an elder with AOD, you'd follow laws and policies for elder abuse. Most times, however, the family is giving AOD to the member without conscious intent to harm them. In these instances, you would do brief interventions (focusing on risks to the member) and harm reduction with the family member involved.[101]

Cultural Factors Influencing AOD Use

Culture influences people's lives, perceptions, resources, and choices—in general and around AOD use. Alcohol and drugs have meanings and "use norms," meaning the "normal" or "acceptable" amounts and times of AOD use. These norms vary widely across nations, religions, ethnicities, socioeconomic classes, gender, age, and combinations thereof.

The Dominant Culture

The U.S. "dominant culture" stresses individualism and autonomy. U.S. health promotion and disease prevention programs "emphasize changes that the individual is supposed to make in his or her behavior; success or failure is very much dependent on individual effort. Likewise, attributions for success or failure are focused on the individual (**good personal will-power, in one case; lack of conviction or self-control in the other**), as are the outcomes of success or failure (an improved or diminished self-confidence, for instance)" (116) This orientation contrasts strongly with approaches used in other cultures and countries. Western European countries tend more toward "a **public health model** with more focus on groups and communities and much less on individuals" (116). Eastern (Asian) countries are far less individualistic and also hold that "different balances are appropriate for different individuals…Individuals in the

[101] Family's AOD use is discussed in Chapter 9.

Eastern view have limited power to change their current situation; individuals in the Western view are seen as nearly all-powerful in changing their current situation" (116). It is helpful to notice that popular U.S. views of individual responsibility –including health moralism as discussed in Chapter 1--reflect a particular cultural perspective. Cultural indoctrination can make us feel passionately that we are "right" about something (itself a uniquely U.S. stance!), when really we are just reflecting our culture.

Members' and Families' Cultures

As noted above, Partnership staff and agencies already have experience in delivering culturally competent services. Below are listed some cultural factors to consider regarding AOD use:

- Traditions, practices, and values of the culture—including the extent of individualism, role expectations, and accepted use of specific drugs
- Belief systems about illness, health and healing, and about AOD problems
- Attitudes toward seeking help for health care, mental health, or substance use problems (102)
- The member's relationship to their culture(s): Are they still connected with their culture, or isolated or ostracized from it?
- If a recent immigrant to U.S.—was that voluntary or coerced, for example, by war? Has the person suffered losses of their homeland, family, status, income, social/cultural norms? Trauma, including multi-generational trauma, is a major contributing factor in AODA. (118, 119, 120)
- Socioeconomic and other barriers to meeting basic needs and prioritizing treatment
- Transportation, housing, food, clothing, household needs
- Childcare (studies show 2 to 3 times better AODA treatment success for women who used childcare services offered at AODA treatment site (121, 122)
- History of or current mistreatment or coercion by governmental, health care or social work professions, and/or members of dominant culture (103)
- The culture's views of AOD use—spiritual, medical, social, personal, community

Cultural Perspectives and Fear of Disclosure

Cultural competency includes not only respect for cultural differences, but also an awareness of the histories of and power imbalances among various cultural groups. AOD use, laws, and practices have disproportionate effects on communities of color, particularly African Americans, Native Americans, and to an increasing degree, Latinos/Hispanics. The following statistics outline the context in which many of your members and families **may be afraid to talk about AOD use** with Partnership staff, especially white ones. You need to understand the context so that you can work well with members and families affected by it. All of the following statistics are from the U.S. Dept. of Justice's website [104]:

- "At current levels of incarceration, newborn Black males in this country have a greater than 1 in 4 chance of going to prison during their lifetimes, while Latin-

[102] (Cohen E and Goode TD, 1999)
[103] (29)
[104] U.S. Dept. of Justice data at http://www.ojp.usdoj.gov/bjs/welcome.html

American [sic] males have a 1 in 6 chance, and white males have a 1 in 23 chance of serving time.[105]"

- Whites comprise **74%** of U.S. illicit drug users and **24%** of drug-related incarcerations[106]
- African Americans comprise **13%** of U.S. illicit drug users, **64%** of U.S. drug-related convictions, and 42% and 58% of drug-related incarcerations (in federal and state prisons respectively; of those, only 5% are large-scale dealers.)
- "Regardless of similar or equal levels of illicit drug use during pregnancy, black women are 10 times more likely than white women to be reported to child welfare agencies for prenatal drug use." [107]

Given these facts, many African Americans and Latinos/Hispanics are understandably likely to be **very fearful of disclosing AOD issues** to Partnership staff, particularly white staff. Being aware of this is a key part of cultural competency.

Building trust, being clear that you want to partner with the member to promote their well-being, and explaining and upholding confidentiality are extra important when cultural dynamics bring high levels of distrust or inequalities. Here are some basic strategies to help you avoid triggering resistance from members or families:

- ✓ Establish a collaborative and trustworthy relationship first.
- ✓ Always transition into AOD use from conversation on other topics. For example, first talk how the person is in general, or first ask other health-related questions
- ✓ A more polite and formal approach may help
- ✓ Discuss AOD use as on a continuum ranging from beneficial to harmful, and AODA as a chronic condition, to avoid the moral model of AODA.[108] Frame AODA as a health issue, or a health and safety issue.

Oppression affects people's levels of chronic stress, anger, despair, self-esteem, and sense of self-efficacy and hope. All of these negative emotional/cognitive states can be major contributors to AOD use. Depending on the individual, open dialogue about these factors might be helpful. Most members of oppressed groups are very conscious of the political and socioeconomic context of their lives.[109] For example, some of the most effective treatment approaches incorporate that systemic context in helping African-Americans move toward recovery (124). African-Americans perceive AOD problems not solely as individual problems but also "within the context of very real historical and systemic forces of oppression and racism in the United

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[106] From Dept. of Justice data updated in 1999: http://www.ojp.usdoj.gov/bjs/pub/ascii/fdo99.txt

[107] "The number of black (non-Hispanic) women incarcerated for drug offenses in State prisons increased by 828 percent from 1986 to 1991" (123)

[108] Oppressive ideologies including racism always include a mix of political, socioeconomic, and "moral" justifications for negative treatment of the oppressed group. Even though, e.g., African Americans and Hispanics tend toward the moral model of AODA (largely due to influence of the church), racist dynamics could be unintentionally introduced if whites are "judging" the moral character of people of color. This problem can be averted if all staff use the chronic conditions paradigm and the nonjudgmental, collaborative interventions recommended in this manual.

[109] Lesbians, gays, and bisexuals may have internalized homophobia and/or been rejected by family and friends. Part of recovery from AODA for them may be finding community and self-esteem.

States that aggressively impinge upon the well-being and life-affirming practices of the individual, the family, and the community"(29). [110]

Compared to the dominant U.S. culture, most other cultures are more grounded in family, community, and spiritual elements. For example, African American traditions are based on

> "…principles of interconnectedness, responsibility to the community, the belief that the essential core that is the self is divine essence, the belief that each person has a God-given purpose in life, and the importance of developing good character. Additionally, a reframing of healing (recovery) from a process of just healing the personal self to a process that stimulates healing of the community engages the client more substantively in a consideration of his substance use. One's own healing represents a healing of the community because of the essential interdependent nature of the African-American communities" (29)

Similarly, for Native Americans,[111] successful approaches stress positive community engagement and traditional spirituality and culture as important sources of self-esteem. For Native women, separate groups with pragmatic supports such as childcare and transportation are most successful (125). Providing supports to promote re-engagement in community ties and traditions is usually the most effective approach. Traditional AODA treatment methods have been only 20 to 40% effective for Native Americans. (125)

Cross-Cultural Misperceptions and AODA

Cultural competency requires awareness of one's own culture and values as well as recognition of cultural differences. An important standard in community-based long-term care—safety—is a good example of cultural differences that can create unintended biases. People's notions of safety are very much affected by race/ethnicity, class, gender, age, culture/subculture; whether they are rural or urban; their perceived vulnerability and ability to protect themselves; and their past experiences of violence. Agencies should attempt to accommodate staff's individual needs around safety, particularly for staff who have been hurt in the past. Yet it is important to recognize how much one's feelings and perceptions are influenced by one's culture. Following is an example of how issues of safety may reflect cultural misunderstandings more than actual risks:

Example

Staff of a home health agency[112] *feel unsafe in a client's home. The house is never locked and people unknown by the staff frequently enter the house, watch TV, read the paper, drink beer, and help themselves to food, music CDs, and magazines. This often occurs when no other family members are present and a staff is alone with the*

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[110] For one example: "African Americans are now the targets of over 40% of the entire alcohol advertisement budget" (36), p. 310).

[111] The age-adjusted alcoholism death rate for Native Americans is 5.5 times the U.S. all-races rate (125). Native Americans have the shortest lifespan and the highest alcohol mortality of any other racial/ethnic group in the U.S. (Yet rates of binge and heavy drinking are approximately the same among Native Americans and whites. (2001 National Household Survey on Drug Abuse, www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/Chapter3.htm)

[112] This example involved a home health agency, not a Partnership agency. The home health agency sought to discharge the client on the basis of perceived lack of staff safety.

member, who is nonverbal. Staff find this particularly frightening in the evenings. There is an implication that the visitors are dangerous because they get drunk. Staff have not discussed their concerns with the family.
When details of the situation are explored, cultural differences in perceptions of safety become evident. For this is a Native American family living on a reservation, where free access to each other's houses and goods is completely normal and accepted. The staff are middle-class white females whose own cultures normalize locked doors and limited sharing of goods only when asked. The family is surprised to hear that the staff felt unsafe, and say that none of their visitors would ever harm them; that in fact there is no danger to them. After the situation is discussed openly, the staff realize that none of the visitors has ever had more than 1 or 2 beers at a time and have never been threatening in any way. The family arranges to introduce staff to more of their visitors, and visitors and staff chat more and get to know each other. Staff begin to learn more about Native American culture, and the agency begins a rewarding collaboration with the community on cultural and health-related projects.

Conclusion

Cultural competency is already a part of Partnership agencies' practice. Some additional issues arise regarding AODA. Family translators should not be used, especially for elders, unless the member requests it. Helping members (and families) reconnect with their community, culture, and spirituality may help immensely with AODA recovery. Culturally specific AODA treatment methods tend to be better received and more effective than mainstream/"generic" methods. Many people prefer culturally specific peer support groups.

It is important to be aware of the cultural context in which people of color may distrust agencies and (white) staff and healthcare providers when it comes to AOD problems. Staff need to understand this to avoid misinterpreting members and families, and to foster truly collaborative nonjudgmental supports for people. An awareness of cultural differences in definitions of safety and of "acceptable" lifestyles is also important to avoid enacting unacknowledged biases.

CHAPTER

9

Chapter 9 – Addressing Family Members' AOD Problems

Introduction

Partnership staff reported that AOD problems among members' families can often be even more challenging than AOD problems among members. This chapter discusses ways that Partnership staff can address members' families' AOD problems. To avoid redundant language of "members' family members," the term "family" will here mean one or more adult family members.

In this chapter, the term "family" will be used to include caregivers and non-caregivers. Of course AOD by caregivers may create concerns over safety and quality of care. However, research indicates that AOD problems among non-caregivers may be dangerous as well. In particular, research indicates that one of the highest risks for domestic violence, including elder abuse, is from **non-caregiving** men with AOD abuse/dependency living in the same household (126, 127, 128, 129, 130). Since you always want to be alert for risk factors of elder abuse, neglect, or domestic violence, it may be just as important to notice and address AOD problems among non-caregivers as among caregivers. This chapter assumes that you will follow relevant laws that cover elder abuse and neglect, domestic violence, and child protection; the chapter focuses on responding to challenging situations when those laws do not apply.

All of what you've learned in this training applies to interventions you can use with families. Of course extra layers of complexity are added because you must consider more factors and negotiate with multiple parties besides the member. Situations can be especially challenging if the family is dependent on the member's monthly social security income, and/or if the member wants to maintain the current arrangement despite risks or actual harms to them. Each situation requires a balancing of risks and safety, and a balancing of ensuring safety with respecting the member's choices.

Analyzing the Problem

Long-term care staff frequently describe the problem as "The family[113] is drunk or using drugs." This statement makes the "solution" appear to be that the family must stop drinking or using drugs—a possibly unrealistic expectation likely to generate frustration. [114] To avoid these tendencies, and to facilitate problem solving (which requires knowledge of details), a helpful first step is to identify the problem more precisely. A family's AOD use may create two types of problems for long-term care agencies:

1. The family's AOD-related behaviors are **causing risks** or harms (i.e., safety concerns) for the member, themselves, and/or to staff
2. The family is **unavailable** to provide assistance the member needs at certain times.

Addressing these issues separately will help keep things clearer and is more likely to point to solutions. First, note that it is **possible** that neither 1 nor 2 is true: It is possible that the family's AOD use does **not** create any risks and does **not** create gaps in caregiving. Staff must be clear on the details of a situation and **assess for, rather than assume, risks**. Following is a list of questions that will help you assess each situation in which family members are using AOD.

Assessing Effects Of Family AOD Use

1. What risk of harm or unmet need occurs for the member?
   - ✓ Abuse or neglect [115, 116] (occurring or risk of it)
   - ✓ Errors in caregiving tasks such as medications, IVs, etc.
   - ✓ Member's unmet needs during those times (to go to bathroom, to be fed or turned, etc.)
   - ✓ No help in case of emergency (e.g., fire, tornado, IV problem) because family is too impaired to respond

2. When do the risks occur, and when not?
   - ✓ Family might use AOD only on weekends or only in evenings.
   - ✓ You may not know these details until after you talk with the family; how to talk with the family is discussed below.

3. Could adaptations meet member's needs during those times?
   E.g., commode, trapeze for self-transfers, Lifeline, walker, hospital bed, etc.

4. Are additional in-home services at those times indicated? When family/caregiver is unable or unwilling to provide assistance, the agency must consider alternative sources of caregiving.

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[113] Again, the term "family" here means one or more adult family members, caregivers or non-caregivers.

[114] See Chapter 1 re the moral model of AODA and Chapter 8 for more discussion of drugs and racism and cultural contexts of perceived safety.

[115] Long-term care practitioners must be alert for signs of abuse or neglect, particularly of frail elders, and must respond in accord with relevant laws and policies.

[116] Highest risk factors for abuse and neglect are caregivers or male family members in household who have AOD problems and/or mental illness (130).

Are there safety concerns for staff? What are the cultural or interpersonal factors that might affect our analysis? Are we seeing AODA as chronic condition and AOD use as normal part of human life?

Addressing Families' AOD Use

It is sometimes difficult to broach the subject of a family member's AOD use. Brief interventions using FRAMES can make it easier, because it provides a structure of what to say. It s important to recognize that resistance is likely to be much more intense than the "usual" brief interventions (in which the focus is on the individual using AOD). Here, your focus is on the effects of the AOD use upon the member. Any perceived threat to the family situation or perceived insult to the family's caregiving is even more volatile than discussing AODA. Understanding this, you can expect resistance and try to strategize to reduce it. Families often have very strong feelings about their caregiving—a complex mix of love, pride and protectiveness mixed with self-sacrifice, stress, and anger. There may be an undercurrent of resentment toward providers (who, after all, only visit). There may be histories of disagreements with you or with other providers. Your member may be at the center of family dynamics, routines, even economics (e.g., when the family depends on the member's social security income). Family members may fear that you will disrupt the family, remove the member, report the AOD use. Knowing all this in advance, and being aware of any cultural dynamics, you can strategize to try to reduce resistance from the family.

Consider which team member might be the best received by the family member. This might be someone who has a closer relationship with the family member, or someone very skilled. Consider cultural dynamics as well.

One option is to exploit the efficacy of brief interventions provided by a health care provider. A **healthcare provider** could do a screen and brief intervention (either in the home or at the clinic) with the family member. It could be explained as outreach the agency is doing with families. With this tactic, the brief interventions would focus on the effects of AOD use upon the family member, thus avoiding the extremely sensitive issue of the member's safety, i.e., quality of caregiving. (Agencies are likely to find any AODA interventions with families to be very cost-effective in the long run.)

1. Establish rapport with the family member: Ask how they are doing; praise their support. If any unrelated issues arise, try to problem solve those first, to reinforce your role as ally and collaborator.

2. Do brief interventions using FRAMES. If possible, express concerns about the family member, not only about the member.

   Example : *Carrie, you do a wonderful job taking care of your mom. I'm worried about you, though. It seems you've been drinking heavily lately. I'm worried that Ethel might need something at a time when you're intoxicated. That could put you both in danger of an accident or a mistake. Ethel could get hurt, and you'd feel*

terrible. So can we figure this out together, to see how to make sure Ethel's taken care of without putting either one of you at risk?

3. Negotiate harm reduction, with plan and close follow-up. *See examples below*

Repeat steps 1 – 3 as often necessary, based on details of the situation and changes over time

Assess for caregiver burnout and quality of life, and provide more supports as needed

Examples of Negotiating Harm Reduction with Family Caregivers

- Family caregiver contracts with you to limit AOD use to particular times so that replacement caregivers can be scheduled for those times.
- Caregiver contracts with you to always have someone in house (e.g., a 12 year old who is comfortable with the responsibility) who can call 911 in an emergency. (This applies if member does not have any unmet needs during times of AOD use.)
- Caregiver contracts with you to never have more than, e.g., 2 or 3 drinks in an evening she is taking care of member; in-home services are provided two evenings a week for caregiver to socialize (and possibly drink more)
- Caregivers contract with you to call agency as far in advance as possible about times they will be unable to do cares (for any reason).
- If caregiver only uses AOD in evenings, evening home visits (e.g., by personal care worker) could be scheduled to meet member's needs.
- If caregiver uses AOD throughout day, several brief visits a day may be needed to meet member's needs.

If Problems Continue

If families do not follow through with a plan, try to find out why. Do not assume the worst; ask. Did they not really like the plan? Did they encounter barriers to it? (Which stage of change are they in? Use some of the strategies from Chapters 3 through 5 to try to reduce resistance and support change.) Because your agency is fundamentally responsible for meeting the member's needs, and because family caregivers may feel overburdened at times, don't hesitate to provide additional supports at this stage. Provide extra respite, provide rewards, praise any progress, keep nurturing this family and provide extra help.

Sometimes families will not cooperate and the member remains at risk. Community-based long-term care staff must sometimes negotiate very complicated issues around families' quality of care. It is especially difficult when competent members acquiesce to poor care or poor relationships.
But if you apply the methods in this training to address AODA, at least families' AODA use won't be much different from other quality of care issues.

If the member's health and safety cannot be met, then the interdisciplinary team will recommend alternative ways to support the member. Alternatives might include helping the member or

family find other informal supports, or recommending that the member move to a group home, assisted living, or nursing home.

Implementation Issues

Community-based long-term care often involves complex issues around family caregivers and Adding AOD problems to the mix can be overwhelming. This chapter presented a process to help staff analyze a situation, and some steps to guide interventions. Given the complexity of quality of care questions and abuse/neglect issues, interdisciplinary teams may need clinical manager's assistance in these situations.

The next page lists some proposed performance expectations for Partnership staff addressing AOD problems. The first half of this list was presented at the end of Chapter 5; what follows includes topics covered in Chapters 6 through 9. The interventions explained in this training can become the minimum standards and the maximum responsibilities for WPP staff. Expectations will be more realistic, feasible, and clear for all. **Minimum standards** can be used to tell staff what they must be sure to do (for example, to advise people with AOD problems to quit or cut back to recommend AODA treatment, and to treat AODA like other chronic conditions). The standards have been designed to capture the **maximum responsibilities** of staff as well. In other words, no matter what happens, if staff followed the standards, they have fulfilled their job responsibilities. Their practice was not negligent and they are not liable for harm resulting from the member's AODA. Each agency can adapt these standards to implement an agency-wide approach to AODA. The standards and training materials can be incorporated as performance standards and policies and procedures. They can also work in quality improvement reviews, to guide retrospective analyses of situations.

Proposed Procedures for Addressing Alcohol or Drug Problems

1. Provide AODA screening if required in job description (e.g., intake staff, team RN) and provide follow up as indicated
2. Respond to any indications of possible AOD problems (including withdrawal) among members or their families

   Paraprofessionals: Report to interdisciplinary team any indications of possible AOD problems among members or their families
3. Employ agency-wide model of AODA as a chronic health condition
4. Negotiate harm reduction, adapted to suit the individual and circumstances
5. Provide brief interventions using FRAMES (includes recommending abstinence and AODA treatment to persons with serious problems or dependency)
6. Provide stage-appropriate interventions and motivational enhancement
7. Address underlying issues—e.g., pain, insomnia, hopelessness, depression, loneliness, grief, loss of purpose in life—with which person may be using AOD to cope
8. Set clear agency limits, informing member (or family) in advance.
9. Provide covered services regardless of their cause

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